SOCIAL SECURITY AMENDMENTS OF 1965

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS

ON

H.R. 6675

TO PROVIDE A HOSPITAL INSURANCE PROGRAM FOR THE AGED UNDER THE SOCIAL SECURITY ACT WITH A SUPPLEMENTARY HEALTH BENEFITS PROGRAM AND AN EXPANDED PROGRAM OF MEDICAL ASSISTANCE, TO INCREASE BENEFITS UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO IMPROVE THE FEDERAL-STATE PUBLIC ASSISTANCE PROGRAM, AND FOR OTHER PURPOSES

MARCH 29, 1965.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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CONTENTS

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Mr. MILLS, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 6675]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. OVERALL PURPOSE AND SCOPE OF THE BILL

Purpose

The overall purpose of H.R. 6675 is as follows:

First, to provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing—

(1) A basic plan providing protection against the costs of hospital and related care financed through a separate payroll tax and separate trust fund;

(2) A voluntary "supplementary" plan providing payments for physicians' and other medical and health services financed through small monthly premiums by individual participants matched equally by Federal Government revenue contributions; and

(3) A greatly expanded medical assistance program for the needy and medically needy which would combine all the vendor medical provisions for the aged, blind, disabled, and families with dependent children, now in five titles of the Social Security Act, under a uniform program and matching formula in a single new title.

Second, to expand the services for maternal and child health, crippled children, and the mentally retarded, and to establish a 5-year program of "special project grants" to provide comprehensive health care and services for needy children of school age or preschool age.

Third, to revise and improve the benefit and coverage provisions and the financing structure of the Federal old-age, survivors', and disability insurance system by—

(1) Increasing benefits by 7 percent across the board with a $4 minimum increase for a worker retiring or who retired age 65 or older;

(2) Continuing benefits to age 22 for children attending school;

(3) Providing actuarially reduced benefits for widows at age 60;

(4) Liberalizing the definition and waiting period for disability insurance benefits;

(5) Paying benefits on a transitional basis to certain persons currently 72 or over who are now ineligible;

(6) Increasing the amount an individual is permitted to earn without losing benefits;

(7) Amending the coverage provisions by:

(*a*) Including self-employed physicians;

(*b*) Covering cash tips;

(*c*) Liberalizing the income treatment for self-employed farmers;

(*d*) Improving certain State and local coverage provisions;

(*e*) Exempting certain religious groups opposed to insurance;

(8) Revising the tax schedule and the earnings base so as to fully finance the changes made; and

(9) Making other miscellaneous improvements.

Fourth, to improve and expand the public assistance programs by—

(1) Increasing the Federal matching share for cash payments for the needy aged, blind, disabled, and families with dependent children;

(2) Eliminating limitations on Federal participation in public assistance to aged individuals in tuberculosis and mental disease hospitals under certain conditions;

(3) Affording the States broader latitude in disregarding certain earnings in determining need for aged recipients of public assistance; and

(4) Making other improvements in the public assistance titles of the Social Security Act.

Scope

The scope of the protection provided is broadly as follows:

Health insurance and medical care for the needy

(1) *Basic plan.*—It is estimated that approximately 17 million insured individuals and 2 million uninsured would qualify on July 1, 1966.

(2) *Voluntary Supplementary plan.*—It is estimated that of the total eligible aged of 19 million, from 80 to 95 percent would participate, which would mean approximately 15.2 to 18 million individuals would be involved.

(3) *Medical assistance for needy.*—The expanded medical assistance (Kerr-Mills) program is estimated to provide new or increased medical assistance to about 8 million needy persons during an early year of operation. States could, in the future, provide aid to as many as twice this number who need help with medical costs.

Old-age, survivors, and disability insurance

It is estimated that the number of persons affected immediately by changes in this title would be as follows:

Provision	*Number affected*
7-percent benefit increase ($4 minimum in primary benefit)	20 million persons.
Child's benefit to age 22 if in school	295,000 children.
Reduced age for widows	185,000 widows.
Reduction in eligibility requirement for certain persons aged 72 or over	355,000 persons.
Liberalization of disability definition	155,000 workers and dependents.

Public assistance

It is estimated that some 7.2 million persons will be eligible for increased cash payments under the Federal-State matching programs. Moreover, it is estimated that 130,000 aged persons in mental and tuberculosis hospitals will potentially be eligible for payments because of the removal of the exclusion of these types of institutions from matching under the public assistance programs.

II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

A. Health Insurance and Medical Care for the Aged

Your committee's bill would add a new title XVIII to the Social Security Act providing two related health insurance programs for persons 65 or over:

(1) A basic plan in part A providing protection against the costs of hospital and related care; and
(2) a voluntary supplementary plan in part B providing protection against the costs of physicians' services and other medical and health services to cover certain areas not covered by the basic plan.

The basic plan would be financed through a separate payroll tax and separate trust fund. The plan would be actuarially sound under conservative cost assumptions. Benefits for persons currently over 65 who are not insured under the social security and railroad retirement systems would be financed out of Federal general revenues.

Enrollment in the supplementary plan would be voluntary and would be financed by a small monthly premium ($3 per month initially) paid by enrollees and an equal amount supplied by the Federal Government out of general revenues. The premiums for social security and railroad retirement beneficiaries who voluntarily enroll would be deducted from their monthly insurance benefits. Uninsured persons desiring the supplemental plan would make the periodic premium payments to the Government.

Your committee's bill would also add a new title XIX to the Social Security Act which would provide a more effective Kerr-Mills program for the aged and extend its provisions to additional needy persons. It would replace with a single uniform category the differing medical provisions for the needy which currently are found in five titles of the Social Security Act.

A description of these three programs follows:

1. BASIC PLAN—HOSPITAL INSURANCE, ETC.

General description.—Basic protection, financed through a separate payroll tax, would be provided by H.R. 6675 against the costs of inpatient hospital services, posthospital extended care services, posthospital home health services, and outpatient hospital diagnostic services for social security and railroad retirement beneficiaries when they attain age 65. The same protection, financed from general revenues, would be provided under a special transitional provision for essentially all people who are now aged 65, or who will reach 65 in the near future, but who are not eligible for social security or railroad retirement benefits.

Effective date.—Benefits would first be effective on July 1, 1966, except for services in extended care facilities which would be effective on January 1, 1967.

Benefits.—The services for which payment would be made under the basic plan include—

(1) inpatient hospital services for up to 60 days in each spell of illness with the patient paying a deductible amount of $40 for each spell of illness; hospital services would include all those ordinarily furnished by a hospital to its inpatients; however, payment would not be made for private duty nursing or for the hospital services of physicians except services provided by interns or residents in training under approved teaching programs;

(2) posthospital extended care (in a facility having an arrangement with a hospital for the timely transfer of patients and for furnishing medical information about patients) after the patient is transferred from a hospital (after at least a 3-day stay) for up to 20 days in each spell of illness; 2 additional days will be added to the 20 days for each day that the person's hospital stay was less than 60 days (up to a maximum of 80 additional days)—the overall maximum for posthospital extended care could thus be 100 days in each spell of illness;

(3) outpatient hospital diagnostic services with the patient paying a $20 deductible amount for each diagnostic study (that is, for diagnostic services furnished to him by the same hospital during a 20-day period); if, within 20 days after receiving such services, the individual is hospitalized as an inpatient in the same hospital, the deductible he paid for outpatient diagnostic services (up to $20) would be credited against the inpatient hospital deductible ($40); and

(4) posthospital home health services for up to 100 visits, after discharge from a hospital (after at least a 3-day stay) or extended care facility and before the begininng of a new spell of illness. Such a person must be in the care of a physician and under a plan established by a physician within 14 days of discharge calling for such services. These services would include intermittent nursing care, therapy, and the part-time services of a home health aide. The patient must be homebound, except that when certain equipment is used the individual could be taken to a hospital or extended care facility or rehabilitation center to receive some of these covered home health services in order to get advantage of the necessary equipment.

No service would be covered as posthospital extended care or as outpatient diagnostic or posthospital home health services if it is of a kind that could not be covered if it were furnished to a patient in a hospital.

A spell of illness would be considered to begin when the individual enters a hospital or extended care facility and to end when he has not been an inpatient of a hospital or extended care facility for 60 consecutive days.

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services would be increased if necessary to keep pace with increases in hospital costs, but no such increase would be made before 1968. For reasons of administrative simplicity, increases in the hospital deductible will be made only when a $5 change is called for and the outpatient deductible will change in $2.50 steps.

Basis of reimbursement.—Payment of bills under the basic plan would be made to the providers of service on the basis of the "reasonable cost" incurred in providing care for beneficiaries.

Administration.—Basic responsibility for administration would rest with the Secretary of Health, Education, and Welfare. The Secretary would use appropriate State agencies and private organizations (nominated by providers of services) to assist in the administration of the program. Provision is made for the establishment of an Advisory Council which would advise the Secretary on policy matters in connection with administration.

Financing.—Separate payroll taxes to finance the basic plan, paid by employers, employees, and self-employed persons, would be earmarked in a separate hospital insurance trust fund established in the Treasury. The amount of earnings (wage base) subject to the new payroll taxes would be the same as for purposes of financing social security cash benefits. The same contribution rate would apply equally to employers, employees, and self-employed persons and would be as follows:

	Percent
1966	0.35
1967–72	.50
1973–75	.55
1976–79	.60
1980–86	.70
1987 and thereafter	.80

The taxable earnings base for the health insurance tax would be $5,600 a year for 1966 through 1970 and would thereafter be increased to $6,600 a year.

The schedule of contribution rates is based on estimates of cost which assume that the earnings base will not be increased above $6,600. If Congress, in later years, should increase the base above $6,600, the tax rates established can be reduced under the cost assumptions underlying the bill.

The cost of providing basic hospital and related benefits to people who are not social security or railroad retirement beneficiaries would be paid from general funds of the Treasury.

2. VOLUNTARY SUPPLEMENTARY INSURANCE PLAN

General description.—A package of benefits supplementing those provided under the basic plan would be offered to all persons 65 and over on a voluntary basis. Individuals who enroll initially would pay premiums of $3 a month (deducted, where possible, from social security or railroad retirement benefits). The Government would match this premium with $3 paid from general funds. Since the minimum increase in cash social security benefits under the bill for workers retiring or who retired at age 65 or older would be $4 a month ($6 a month for man and wife receiving benefits based on the same earnings record), the benefit increases would fully over the amount of monthly premiums.

Enrollment.—Persons who have reached age 65 before January 1, 1966, will have an opportunity to enroll in an enrollment period which begins on the first day of the second month after the month of enactment and ends March 31, 1966.

Persons attaining age 65 subsequent to December 31, 1965, will have enrollment periods of 7 months beginning 3 months before the month of attainment of age 65.

In the future, general enrollment periods will be from October to December 31, in each odd numbered year. The first such period will be October 1 to December 31, 1967.

No person may enroll more than 3 years after the close of the first enrollment period in which he could have enrolled.

There will be only one chance to reenroll for persons who are in the plan but drop out, and the reenrollment must occur within 3 years of termination of the previous enrollment.

Coverage may be terminated (1) by the individual filing notice during an enrollment period, or (2) by the Government, for nonpayment of premiums.

A State would be able to provide the supplementary insurance benefits its public assistance recipients who are receiving cash assistance if it chooses to do so.

Effective date.—Benefits will be effective beginning July 1, 1966.

Benefits.—The voluntary supplementary insurance plan would cover physicians' services, home health services, hospital services in psychiatric institutions, and numerous other medical and health services in and out of medical institutions.

There would be an annual deductible of $50. Then the plan would cover 80 percent of the patient's bill (above the deductible) for the following services:

(1) Physicians' and surgeons' services, whether furnished in a hospital, clinic, office, in the home or elsewhere;

(2) Hospital care for 60 days in a spell of illness in a mental hospital with a 180-day lifetime maximum;

(3) Home health service (with no requirement of prior hospitalization) for up to 100 visits during each calendar year;

(4) Additional medical and health services, whether provided in or out of a medical institution, including the following:

(*a*) Diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests;

(*b*) X-ray, radium, and radioactive isotope therapy;

(*c*) Ambulance services; and

(*d*) Surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations; rental of durable medical equipment such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home, prosthetic devices (other than dental) which replace all or part of an internal body organ; braces and artificial legs, arms, eyes, etc.

There would be a special limitation on outside-the-hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year would be limited, in effect, to $250 or 50 percent of the expenses, whichever is smaller.

Administration by carriers: Basis for reimbursement.—The Secretary of Health, Education, and Welfare would be required, to the extent possible, to contract with carriers to carry out the major administrative functions relating to the medical aspects of the voluntary supplementary plan such as determining rates of payments under the

program, holding and disbursing funds for benefit payments, and determining compliance and assisting in utilization review. No contract is to be entered into by the Secretary unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The contract must provide that the carrier take necessary action to see that where payments are on a cost basis (to institutional providers of service), the cost is reasonable cost. Correspondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services), the carrier must see that such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the other policyholders and subscribers of the carrier. Payment by the carrier for physicians' services will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge will be the full charge for the service.

Financing.—Aged persons who enroll in the supplemental plan would pay monthly premiums of $3. Where the individual is currently receiving monthly social security or railroad retirement benefits, the premiums would be deducted from his benefits.

The Government would help finance the supplementary plan through a payment from general revenues in an equal amount of $3 a month per enrollee. To provide an operating fund, if necessary, at the beginning of the supplementary plan, and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis) equal to $18 per aged person estimated to be eligible in July 1966 when the supplementary plan goes into effect.

The individual and Government contributions would be placed in a separate trust fund for the supplementary plan. All benefit and administrative expenses under the supplementary plan would be paid from this fund.

Premium rates for enrolled persons (and the matching Government contribution) would be increased from time to time if medical costs rise, but not more often than once every 2 years. The premium rate for a person who enrolls after the first period when enrollment is open to him or who reenrolls after terminating his coverage would be increased by 10 percent for each full year he stayed out of the program.

Medical expense deduction.—The health care provisions of your committee's bill have a relationship to the medical expense deductions allowed under the Internal Revenue Code. In the past the 3-percent limitation in the case of medical care expenses and the 1-percent limitation applied to expenditures for medicines and drugs were waived for persons 65 or over in recognition of the fact that medical expenses generally constituted a heavy financial burden for older people. In the past, however, there was no broad-coverage health insurance plan for older persons. The health insurance provisions of your committee's bill are designed to meet these problems in a generally comprehensive manner. The historical basis for the special medical expense provisions in the tax law for the relief of older taxpayers, therefore, no longer appears to exist. For this reason the bill provides that the 3-percent floor on medical expense deductions, as

well as the 1-percent limitation on medicines and drugs, is to apply to those age 65 or over in the same manner as it presently applies to those under age 65. This will have the effect of partially or fully recovering the $3 monthly premium paid from general funds of the Treasury from those aged persons who have taxable income, depending on the amount of their taxable income.

To encourage the purchase of hospital insurance by all taxpayers, the bill provides a special deduction, available to those who itemize their deductions, for one-half of any premiums paid for insurance of medical care expenses whether or not they have medical expenses in excess of the 3-percent floor, but this deduction may not exceed $250.

Another change limits the insurance premiums which may be taken into account to those which arise from coverage of medical care expenses. Still a further change treats as current, qualifying medical care expenses (subject to limitations) the prepayment before age 65 of insurance for medical care after age 65.

3. IMPROVEMENT AND EXTENSION OF KERR-MILLS MEDICAL ASSISTANCE PROGRAM

Purpose and scope.—In order to provide a more effective Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons, the bill would establish a single and separate medical care program to replace the differing provisions for the needy which currently are found in five titles of the Social Security Act.

The new title (XIX) would extend the advantages of an expanded medical assistance program not only to the aged who are indigent but also to needy individuals in the dependent children, blind, and permanently and totally disabled programs and to persons who would qualify under those programs if in sufficient financial need.

Medical assistance under title XIX must be made available to all individuals receiving money payments under these programs and the medical care or services available to all such individuals must be equal in amount, duration, and scope. Effective July 1, 1967, all children under age 21 must be included who would, except for age, be dependent children under title IV.

Inclusion of the medically indigent aged not on the cash assistance rolls would be optional with the States but if they are included comparable groups of blind, disabled, and parents and children must also be included if they need help in meeting necessary medical costs. Moreover, the amount and scope of benefits for the medically indigent could not be greater than that of recipients of cash assistance.

The current provisions of law in the various public assistance titles of the act providing vendor medical assistance would terminate upon the adoption of the new program by a State and must terminate no later than June 30, 1967.

Scope of medical assistance.—Under existing law, the State must provide "some institutional and noninstitutional care" under the medical assistance for the aged program. There are no minimum benefit requirements at all under the other public assistance vendor medical programs.

The bill would require that by July 1, 1967, under the new program a State must provide inpatient hospital services, outpatient hospital

services, other laboratory and X-ray services, skilled nursing home services, and physicians' services (whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere) in order to receive Federal participation. Coverage of other items of medical service would be optional with the States.

Eligibility.—Improvements would be effectuated in the program for the needy elderly by requiring that the States must provide a flexible income test which takes into account medical expenses and does not provide rigid income standards which arbitrarily deny assistance to people with large medical bills. In the same spirit the bill provides that no deductible, cost sharing, or similar charge may be imposed by the State as to hospitalization under its program and that any such charge on other medical services must be reasonably related to the recipient's income or resources. Also important is the requirement that elderly needy people on the State programs be provided assistance to meet the deductibles that are imposed by the new basic program of hospital insurance. Also where a portion of any deductible or cost sharing required by the voluntary supplementary program is met by a State program, the portion covered must be reasonably related to the individual's income and resources. No income can be imputed to an individual unless actually available; and the financial responsibility of an individual for an applicant may be taken into account only if the applicant is the individual's spouse or child who is under age 21 or blind or disabled.

Increased Federal matching.—The Federal share of medical assistance expenditures under the new program would be determined upon a uniform formula with no maximum on the amount of expenditures which would be subject to participation There is no maximum under present law on similar amounts for the medical assistance for the aged program. The Federal share, which varies in relation to a State's per capita income, would be increased over current medical assistance for the aged matching so that States at the national average would receive 55 percent rather than 50 percent, and States at the lowest level could receive as much as 83 percent as contrasted with 80 precent under existing law.

In order to receive any additional Federal funds as a result of expenditures under the new program, the States would need to continue their own expenditures at their present rate. For a specified period, any State that did not reduce its own expenditures would be assured of at least a 5-percent increase in Federal participation in medical care expenditures. As to professional medical personnel used in the administration of the program, the bill would provide a 75-percent Federal share as compared with the 50–50 Federal-State sharing for other administrative expenses.

Administration.—The State agency administering the new program would have to be the same as that administering the old-age assistance program. As some States have done under existing law, such an agency could arrange for provision of medical care by or through the State health agency. The bill specifically provides as a State plan requirement that cooperative agreements be entered into with State agencies providing health services and vocational rehabilitation services looking toward maximum utilization of these services in the provision of medical assistance under the plan.

Effective date.—January 1, 1966.

4. COST OF HEALTH CARE PLANS

Basic plan.—Benefits and administrative expenses under the basic plan would be about $1 billion for the 6-month period in 1966 and about $2.3 billion in 1967. Contribution income for those years would be about $1.6 and $2.6 billion, respectively. The costs for the uninsured (paid from general funds) would be about $275 million per year for early years

Voluntary supplementary plan.—Costs of the voluntary supplementary plan would depend on how many of the aged enrolled.

If 80 percent of the eligible aged enrolled, benefit costs (and administrative expenses) of the supplementary plan would be about $195 million to $260 million in the last 6 months of 1966 and about $765 million to $1.02 billion in 1967. Premium income from enrollees for those years would be about $275 and $560 million, respectively. The matching Government contribution would equal the premiums.

If 95 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about $230 to $310 million in 1966 and about $905 million to $1.22 billion in 1967. Premium income from enrollees for those years would be about $325 and $665 million, respectively. The Government contribution would equal the premiums.

Public assistance plan.—It is estimated that the new program will increase the Federal Government's contribution about $200 million in a full year of operation over that in the programs operated under existing law.

B. Child Health Amendments

Maternal and child health and crippled children.—The bill would increase the amount authorized for maternal and child health services over current authorizations by $5 million for fiscal year 1966 and by $10 million in each succeeding fiscal year, as follows:

Fiscal year	Existing law	Under bill
1966	$40,000,000	$45,000,000
1967	40,000,000	50,000,000
1968	45,000,000	55,000,000
1969	45,000,000	55,000,000
1970 and after	50,000,000	60,000,000

The authorizations for crippled children's service would be increased by the same amounts.

The increases would assist the States, in both these programs, in moving toward the goal of extending services with a view of making them available to children in all parts of the State by July 1, 1975.

Crippled children-training personnel.—The bill would also authorize $5 million for the fiscal year 1967, $10 million for fiscal 1968, and $17.5 million for each succeeding fiscal year to be for grants to institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps.

Health care for needy children.—A new provision is added authorizing the Secretary of Health, Education, and Welfare to carry out a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool

children, particularly in areas with concentrations of low-income families. The grants would be to State health agencies, to the State agencies administering the crippled children's program, to any school of medicine (with appropriate participation by a school of dentistry), and any teaching hospital affiliated with such school, to pay not to exceed 75 percent of the cost of the project. Projects would have to provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, including dental services, with treatment, correction of defects, and aftercare limited to children in low-income families.

An appropriation of $15 million would be authorized for the fiscal year ending June 30, 1966; $35 million for the fiscal year ending June 30, 1967; $40 million for the fiscal year ending June 30, 1968; $45 million for the fiscal year ending June 30, 1969; and $50 million for the fiscal year ending June 30, 1970.

Mental retardation planning.—Title XVII of the act would be amended to authorize grants totaling $2,750,000 for each of 2 fiscal years—the fiscal year ending June 30, 1966, and fiscal year ending June 30, 1967. The funds would be available during the 3-year period July 1, 1965, to June 30, 1968. The grants would be for the purpose of assisting States to implement and followup on plans and other steps to combat mental retardation authorized under this title of the Social Security Act.

C. Old-Age, Survivors, and Disability Insurance Amendments

1. BENEFIT CHANGES

(*a*) *7-percent across-the-board increase in old-age, survivors, and disability insurance benefits*

The bill provides a 7-percent across-the-board benefit increase, effective retroactively beginning with January 1965, with a minimum increase of $4 for retired workers at age 65. These increases will be made for the 20 million social security beneficiaries now on the rolls.

Monthly benefits for workers who retire at or after 65 would be increased to a new minimum of $44 (now $40) and to a new maximum of $135.90 (now $127). In the future, creditable earnings under the increase in the contribution and benefit base to $5,600 a year (now $4,800) would make possible a maximum benefit of $149.90.

The maximum amount of benefits payable to a family on the basis of a single earnings record would be related to the worker's average monthly earnings at all earnings levels. Under present law, there is a $254 limit on family benefits which operates over a wide range of average monthly earnings. Under the bill, until 1971, the highest family maximum would be $312.

Under the second-step increase in the wage base to $6,600 to be effective in 1971, also provided in the bill, the worker's primary benefit would range from a minimum of $44 to a future possible maximum of $167.90 a month. Maximum family benefits up to $368 would also be payable.

(*b*) *Payment of child's insurance benefits to children attending school or college after attainment of age 18 and up to age 22*

H.R. 6675 includes the provision adopted by both House and Senate last year which would continue to pay a child's insurance benefit

until the child reaches age 22, provided the child is attending a public or an accredited school, including a vocational school or a college, as a full-time student after he reaches age 18. Children of deceased, retired, or disabled workers would be included. No mother's or wife's benefits would be payable if the only child in the mother's care is one who has attained age 18 but is in school.

This provision will be effective January 1, 1965. It is estimated that 295,000 children will be able to receive benefits for a typical school month in 1965 as a result of this provision.

(*c*) *Benefits for widows at age 60*

The bill would provide the option to widows of receiving benefits beginning at age 60, with the benefits payable to those who claim them before age 62 being actuarially reduced to take account of the longer period over which they will be paid. Under present law, full widow's benefits and actuarially reduced worker's and wife's benefits are payable at age 62.

This provision, adopted by both Houses of Congress last year, would be effective for the second month after the month of enactment. It is estimated that 185,000 widows will be able to get benefits immediately under this provision.

(*d*) *Amendment of disability program*

(i) *Definition.*—H.R. 6675 would eliminate the present requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration, and instead provide that an insured worker would be eligible for disability benefits if he has been totally disabled throughout a continuous period of at least 6 calendar months. Benefits payable by reason of this change would be paid for the second month following the month of enactment.

(ii) *Payment period.*—The period during which an individual must be under a disability prior to entitlement of benefits is reduced by 1 month under the bill. Disability benefits would be payable beginning with the last month of the 6-month waiting period rather than with the first month after the 6-month waiting period as under existing law. This change would be applicable to all cases in which the last month of the waiting period occurs after the month of enactment.

It is estimated some 155,000 disabled workers and dependents will be benefited by these provisions.

Certain changes are also made in the provision terminating disability benefits and waiving subsequent waiting periods so as to make them more restrictive when applied to shorter term disabilities.

(*iii*) *Entitlement to disability benefits after entitlement to benefits payable on account of age.*—Under the bill, a person who becomes entitled before age 65 to a benefit payable on account of old age could later become entitled to disability insurance benefits.

(*iv*) *Allocation of contribution income between OASI and DI trust funds.*—Under the bill, an additional one-fourth of 1 percent of taxable wages and three-sixteenths of 1 percent of taxable self-employment income would be allocated to the disability insurance trust fund, bringing the total allocation to three-fourths of 1 percent and nine-sixteenths of 1 percent, respectively, beginning in 1966.

(*e*) *Benefits to certain persons at age 72 or over*

Your committee's bill adopts a provision approved by the House and Senate last year, which would liberalize the eligibility requirements by providing a basic benefit of $35 at age 72 or over to certain persons with a minimum of three quarters of coverage acquired at any time since the beginning of the program in 1937. To accomplish this, a new concept of "transitional insured status" is provided. Present law requires a minimum of six quarters of coverage in employment or self-employment.

(*i*) *Men and women workers.*—The concept of "transitional insured status" which would make an individual eligible for an old-age or wife's benefit provides that the oldest workers will receive benefits with only three quarters of coverage, under the bill. These three quarters may have been acquired at any time since the inception of the program in 1937. For those who are not quite so old, the quarters of coverage requirement would increase until the requirement merges with the present minimum requirement of six quarters.

The following table illustrates the operation of the "transitional insured status" provision for workers.

Transitional insured status requirements with respect to workers benefits [1]

Men		Women	
Age (in 1965)	Quarters of coverage required	Age (in 1965)	Quarters of coverage required
76 or over	3.	73 or over	3.
75	4.	72	4.
74	5.	71	5.
73 or younger	6 or more.	70 or younger	6 or more.

[1] Benefits will not be payable, however, until age 72.

(*ii*) *Widows.*—Any widow who is age 72 or over in 1966, if her husband died or reached age 65 in 1954 or earlier, could get a widow's benefit if her husband had at least three quarters of coverage. Present law requires six quarters.

If the husband died or reached 65 in 1955, the requirement would be four quarters. If he died or reached 65 in 1956, the requirement would be five quarters. If he died or reached 65 in 1957 or later, the minimum requirement would be six quarters, the same as present law.

For widows reaching age 72 in 1967 and 1968, there is a "grading-in" of the quarters of coverage requirement; which would be four or five quarters of coverage, respectively. Widows reaching age 72 in in 1969 or after would be subject to the requirements of existing law of six or more quarters of coverage.

The table below sets forth the requirements as to widows:

Transitional insured status requirements with respect to widow's benefits

Year of husband's death (or attainment of age 65, if earlier)	Present quarters required	Proposed quarters required for widow attaining age 72 in—		
		1966 or before	1967	1968
1954 or before	6	3	4	5.
1955	6	4	4	5.
1956	6	5	5	5.
1957 or after	6 or more	6 or more	6 or more	6 or more.

(*iii*) *Basic benefits.*—Men and women workers who would be eligible under the above-described provisions for workers would receive a basic benefit of $35 a month. A wife who is aged 72 or over (and who attains that age before 1969) would receive one-half of this amount, $17.50. No other dependents' basic benefits would be provided under these provisions.

Widows would receive $35 a month under the above-described provision.

These provisions would become effective for the second month after the month of enactment, at which time an estimated 355,000 people would be able to start receiving benefits.

(*f*) *Retirement test*

H.R. 6675 liberalizes the social security earned income limitation so that the uppermost limit of the "band" of a $1 reduction in benefits for each $2 in earnings is raised from $1,700 to $2,400. Under existing law the first $1,200 a year in earnings is wholly exempted, and there is a $1 reduction in benefits for each $2 of earnings up to $1,700 and $1 for $1 above that amount.

Your committee's bill would increase the $1 for $2 "band" so that it would apply between $1,200 and $2,400, with $1 for $1 reductions above $2,400. This change is effective as to taxable years ending after 1965.

The bill also exempts certain royalties received in or after the year in which a person reaches age 65 from copyrights and patents obtained before age 65, from being counted as earnings for purposes of this test, effective as to taxable years beginning after 1964.

(*g*) *Wife's and widow's benefits for diveroced women*

Your committee's bill would authorize payments of wife's and widow's benefits to the divorced wife aged 62 or over of a retired, deceased, or disabled worker if she had been married to the worker for at least 20 years before the date of the divorce and if her divorced husband was making (or was obligated by a court to make) a substantial contribution to her support when he became entitled to benefits, became disabled, or died. H.R. 6675 would also provide that a wife's benefits would not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years. Provision is also made for the reestablishment of benefit rights for a widow or a wife who remarries and the subsequent marriage lasts less than 20 years. These changes are effective for the second month following the month of enactment.

(*h*) *Adoption of child by retired worker*

Your committee's bill would change the provisions relating to the payment of benefits to children who are adopted by old-age insurance beneficiaries to require that, where the child is adopted after the worker becomes entitled to an old-age benefit, (1) the child must be living with worker (or adoption proceedings have begun) in or before the month when application for old-age benefits is filed; (2) the child must be receiving one-half of his support for the entire year before the worker's entitlement; and (3) the adoption must be completed within 2 years after the worker's entitlement.

2. COVERAGE CHANGES

The following coverage provisions were included:

(*a*) *Physicians and interns*

Self-employed physicians would be covered for taxable years ending after December 31, 1965. Interns would be covered beginning on January 1, 1966.

(*b*) *Farmers*

Provisions of existing law with respect to the coverage of farmers would be amended to provide that farm operators whose annual gross earnings are $2,400 or less (instead of $1,800 or less as in existing law) can report either their actual net earnings or 66⅔ percent (as in present law) of their gross earnings. Farmers whose annual gross earnings are over $2,400 would report their actual net earnings if over $1,600, but if actual net earnings are less than $1,600, they may instead report $1,600. (Present law provides that farmers whose annual gross earnings are over $1,800 report their actual net earnings if over $1,200, but if actual net earnings are less than $1,200, they may report $1,200.)

(*c*) *Cash tips*

Coverage of cash tips received by an employee in the course of his employment as wages would be provided, effective as to tips received after 1965.

(*i*) *Reporting of tips.*—The employee would be required to report to his employer in writing the amount of tips received and the employer would report the employee's tips along with the employee's regular wages. The employee's report to his employer would include tips paid to him through the employer as well as those received directly from customers of the employer. Tips received by an employee which do not amount to a total of $20 a month in connection with his work for any one employer would not be covered and would not be reported.

(*ii*) *Tax on tips.*—The employer would be required to withhold social security taxes only on tips reported by the employee to him. Unlike the provision in last year's House bill, this provision requires the employer to withhold income tax on such reported tips.

The employer would be responsible for the social security tax on tips only if the employee reported the tips to him within 10 days after the end of the month in which the tips were received. The employer would be permitted to gear these new procedures into his usual payroll periods. The employer would pay over his own and the employee's share of the tax on these tips and would include the tips with his regular reports of wages. If at the time the employee report is due (or, in cases where the report is made earlier—if between the making of the report and the time it is due), the employer does not have unpaid wages or remuneration of the employee under his control sufficient to cover the employee's share of the social security tax applicable to the tips reported, the employee will pay his share of the tax with his report.

If the employee does not report his tips to his employer within 10 days after the end of the month involved, the employer would have no liability. In such a case the employee alone would be liable not

only for the amount of the employee tax but also an additional amount equal to the employee tax.

For purposes of withholding income tax on tips, the employer is required to deduct and withhold only on the tips reported to him and only to the extent that the tax can be deducted and withheld before the close of the calendar year from wages (excluding tips, but including funds turned over to the employer by the employee for such purpose) under the control of the employer.

(d) State and local government employees

Several changes made by the bill would facilitate social security coverage of additional employees of State and local governments.

(e) Exemption of certain religious sects

Members of certain religious sects may be exempt from the tax on self-employment income and from social security coverage upon application which would be accompanied by a waiver of benefit rights.

An individual eligible for the exemption must be a member of a recognized religious sect (or a division of a sect) who is an adherent of the established teachings of such sect by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance, making payments in the event of death, disability, old-age, or retirement, or making payments toward the cost of or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act).

The Secretary of Health, Education, and Welfare must find that such sect has such teachings and has been in existence at all times since December 31, 1950, and that it is the practice for members of such sect to make provision for their dependent members which, in the Secretary's judgment, is reasonable in view of their general level of living. The exemption for previous years (taxable years ending prior to December 31, 1965) must be filed by April 15, 1966.

The exemption would be effective as early as taxable years beginning after December 31, 1950.

3. MISCELLANEOUS

(a) Filing of proof

H.R. 6675 extends indefinitely the period of filing of proof of support for dependent husbands, widowers and parent's benefits, and for filing application for lump-sum death payments where good cause exists for failure to file within the initial 2-year period.

(b) Automatic recomputation of benefits

The benefits of people on the rolls would be recomputed automatically each year to take account of any covered earnings that the worker might have had in the previous year and that would increase his benefit amount. Under existing law there are various requirements that must be met in order to have benefits recomputed, including filing of an application and earnings of over $1,200 a year after entitlement.

(c) Military wage credits

Your committee's bill revises the present provision authorizing reimbursement of the trust funds out of general revenue for gratuitous social security wage credits for servicemen so that such payments will be spread over the next 50 years.

4. FINANCING OF OASDI AMENDMENTS

The benefit provisions of H.R. 6675 are financed by (1) an increase in the earnings base from $4,800 to $5,600 (effective January 1, 1966), and $6,600 (effective 1971), and (2) a revised tax rate schedule.

The tax rate schedule under existing law and the revised schedule provided by the bill for the OASDI program follow:

[In percent]

Years	Employer-employee rate (each)		Self-employed rate	
	Present law	Bill	Present law	Bill
1965	3.625	3.625	5.4	5.4
1966	4.125	4.0	6.2	6.0
1967	4.125	4.0	6.2	6.0
1968	4.625	4.0	6.9	6.0
1969–72	4.625	4.4	6.9	6.6
1973 and after	4.625	4.8	6.9	7.0

5. AMOUNT OF ADDITIONAL BENEFITS IN THE FULL YEAR 1966

7 percent benefit increase ($4 minimum in primary benefit)	$1,430,000,000.
Child's benefit to age 22 if in school	$195,000,000.
Reduced age for widows	$165,000,000 (no long-range charge to system because of actuarial reduction).
Reduction in eligibility requirement for certain persons aged 72 or over	$140,000,000.
Liberalization of disability definition	$105,000,000.
Liberalization of retirement test	$65,000,000.

D. Public Assistance Amendments

1. INCREASED ASSISTANCE PAYMENTS

The Federal share of payments under all State public assistance programs is increased a little more than an average of $2.50 a month for the needy aged, blind, and disabled and an average of about $1.25 for needy children, effective January 1, 1966. This is brought about by revising the matching formula for the needy aged, blind, and disabled (and for the adult categories in title XVI) to provide a Federal share of $31 out of the first $37 (now twenty-nine thirty-fifths (29/35) of the first $35) up to a maximum of $75 (now $70) per month per individual on an average basis. The matching formula is revised for aid to families with dependent children so as to provide a Federal share of five-sixths (5/6) of the first $18 (now fourteen-seventeenths (14/17) of the first $17) up to a maximum of $32 (now $30). A provision is included so that States will not receive additional Federal funds except to the extent they pass them on to individual recipients. Effective January 1, 1966. Cost About $150 million a year.

2. TUBERCULAR AND MENTAL PATIENTS

H.R. 6675 removes the exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been

diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. The bill requires as condition of Federal participation in such payments to, or for, patients in mental hospitals certain agreements and arrangements to assure that better care results from the additional Federal money. The States will receive additional Federal funds under this provision only to the extent they increase their expenditures for mental health purposes under public health and public welfare programs. The bill also removes restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions.

Effective January 1, 1966. Cost: About $75 million a year.

3. PROTECTIVE PAYMENTS TO THIRD PERSONS

A provision for protective payments to third persons on behalf of old-age assistance recipients (and recipients on combined program, title XVI program) unable to manage their money because of physical or mental incapacity is added by H.R. 6675. Effective January 1, 1966.

4. EARNINGS EXEMPTION UNDER OLD-AGE ASSISTANCE

Your committee's bill increases earnings exemption under old-age assistance program (and aged in combined program) so that a State may, at its option, exempt the first $20 (now $10) and one-half of the next $60 (now $40) of a recipient's monthly earnings. Effective January 1, 1966. Cost: About $1 million first year.

5. DEFINITION OF MEDICAL ASSISTANCE FOR AGED

H.R. 6675 modifies the definition of medical assistance for the aged so as to allow Federal sharing as to old-age assistance recipients for the month they are admitted to or discharged from a medical institution. Effective July 1, 1965. Cost: About $2 million.

6. EXEMPTION OF RETROACTIVE OASDI BENEFIT INCREASE

The bill adds a provision which would allow the States to disregard so much of the OASDI benefit increase (including the children in school after 18 modification) as is attributable to its retroactive effective date.

7. ECONOMIC OPPORTUNITY ACT EARNINGS EXEMPTION

H.R. 6675 also provides a grace period for action by States that have not had regular legislative sessions, whose public assistance statutes now prevent them from disregarding earnings of recipients received under the Economic Opportunity Act.

8. JUDICIAL REVIEW OF STATE PLAN DENIALS

The bill provides for judicial review of the denial of approval by the Secretary of Health, Education, and Welfare of State public assistance plans and of his action under such programs or noncompliance with State plan conditions in the Federal law.

III. GENERAL DISCUSSION OF THE BILL

A. Provisions Related to Health Care

Today, few older people are free of the fear that costly illness will exhaust their savings. In many instances the one or more episodes of hospitalization which virtually all aged people will experience can quickly dissipate whatever savings they have been able to accumulate for their later years. The frequent medical attention required by older people suffering from chronic illness can also be a serious drain on their financial resources

A large and growing proportion of the elderly applying for public assistance have had to do so only because they cannot afford needed health care. Frequently the assistance for which they must apply is very limited in scope and inadequate to meet their needs.

Your committee has been concerned about this problem for a number of years. As may be recalled, in 1960 in the 86th Congress after very careful and exhaustive review of the situation and many proposed solutions, the Committee on Ways and Means concluded that further Federal legislation was necessary. The result was the formulation and enactment of the medical assistance for the aged program, more popularly referred to as the "Kerr-Mills" program. At that time it was the view of your committee that such a program should be undertaken to determine whether it would or could adequately meet the national need. It has now been 5 years since enactment of the 1960 Social Security Amendments and there has been opportunity to evaluate the implementation of the medical assistance for the aged program and to formulate a judgment as to the extent to which this national problem is being met. The Committee on Ways and Means has conducted public hearings in the past two Congresses on this subject, the more recent of which was just last year. Although your committee believes that the Kerr-Mills legislation as a whole has been very beneficial to the needy aged in our country, it has now concluded that the overall national problem of adequate medical care for the aged has not been met to the extent desired under existing legislation because of the failure of some States to implement to the extent anticipated and thus the existing program is inadequate to solve the problem. Your committee, therefore, has concluded that a more comprehensive Federal program as to both persons who can qualify and protection afforded is required.

Therefore, a threefold approach to meet this national problem has been developed. First, since your committee believes that Government action should not be limited to measures that assist the aged only after they have become needy, your committee recommends more adequate and feasible health insurance protection under two separate but complementary programs which would contribute toward making economic security in old age more realistic, a more nearly attainable goal for most Americans. In addition, your committee recommends,

as will be discussed later in this report, a strengthening of the medical assistance provisions of the Social Security Act so that adequate medical aid may be provided for needy people.

The first of the two insurance programs consists of protection against the costs of hospital and related care. This hospital insurance plan would be financed through a new special tax separate from existing social security taxes and the contributions collected would be kept entirely separate from the funds of the existing program in a new Federal hospital insurance trust fund. The proposed hospital insurance would be financed through the new tax contributions during the individual's working lifetime with benefits available at age 65.

In past amendments to the Social Security Act, when new programs have been developed or when significant changes have been made to meet a national need, the Congress has followed the practice of extending the new or enhanced benefits not only to those who will become eligible for them in future years but also to the individuals then currently on the rolls. This has been done, of course, with the knowledge that the current beneficiaries on the rolls have not made contributions specifically for increased benefits or the new benefits then being provided. For example, every cash benefit increase which has been provided has been made equally available to the currently retired as well as to those who would retire in the future. A further example is the extension of the disability insurance benefit provisions in 1956 to both the then currently disabled individuals (who met the requirements) as well as to those would become disabled in the future (and who would meet the eligibility requirements). This, of course, does mean that the already-retired group, which has made no contributions for the hospital insurance part of the program, represents in this sense an "unfunded" liability which has to be met out of future contributions. However, the practice has always been to cover the present beneficiaries and basic to it is the recognition that the problem which such new legislation is designed to meet exists equally with regard to them as with regard to those who will become eligible in the future. It may be noted that the same practices are often followed under private pension plans—namely, to extend benefit liberalizations to existing pensioners on the rolls when doing so for future pensioners.

The second of the two insurance programs is a voluntary supplementary health insurance plan that would cover a substantial part of the cost of physicians' services and a number of other health items and services not covered under the hospital insurance program. At the beginning the voluntary supplementary plan would be financed through monthly premiums of $3, and through equal, matching contributions from Federal Government general revenues. The combined coverage of the two insurance plans would result in protection for the elderly of a quality that only a few older people can now afford. Most elderly people could be expected to have the protection of both of these insurance programs.

The provision of insurance against the covered costs would encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged.

The bill specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or

operation of medical facilities. Further, the bill specifically provides that a beneficiary may obtain services from any participating institution, agency, or person who undertakes to provide him with the services. The responsibility for, and the control of, the care of the beneficiaries rests with the hospitals, extended care facilities, the beneficiaries' physicians, etc.

There will be no coverage of, or payment for, physicians' services under the hospital insurance program, which is financed through the separate payroll tax. Coverage of physicians' services is limited to the voluntary supplementary program which is financed by premiums of beneficiaries and from general funds of the Treasury.

In establishing the complementary plans for medical care for the aged in this bill, no special recognition is being given to the lower rate of hospital utilization which might be experienced by aged persons under comprehensive health care plans. However, it is not the intention of your committee by this action to adversely affect those organizations which provide and operate comprehensive health care services. On the other hand, it is the hope of your committee that the development of comprehensive health care plans be encouraged.

1. BASIC PLAN—HOSPITAL INSURANCE, ETC.

(a) *Eligibility for protection under the basic plan*

The proposed basic hospital insurance would be provided (on the basis of a new section in title II of the act) for people aged 65 and over who are entitled to monthly social security benefits or to annuities under the Railroad Retirement Act. In addition, people who are now aged 65 or will reach age 65 within the next few years and who are not insured under the social security or railroad programs would nevertheless be covered under the basic plan. In July 1966, when the program would become effective, about 17 million people aged 65 and over who are eligible for social security or railroad retirement benefits, and about 2 million aged who would be covered under a special transitional provision, would have the proposed basic hospital insurance.

Included under the special provision would be all uninsured people who have reached 65 before 1968. As to persons reaching 65 after 1967, they would have to have the quarters of coverage that are indicated in the following table:

Quarters of coverage required for OASI cash benefits as compared to hospital insurance

Year attains age 65	Men		Women	
	OASI	Hospital insurance	OASI	Hospital insurance
1967 or before	6–16	0	6–13	0
1968	17	6	14	6
1969	18	9	15	9
1970	19	12	16	12
1971	20	15	17	15
1972	21	18	18	(1)
1973	22	21	----	----
1974	23	(1)	----	----

[1] Same as OASI.

As indicated in the table, by 1974 the quarter coverage required for cash benefits and hospitalization insurance benefits will be the same and the "transitional" provision will phase out.

Together, these two groups comprise virtually the entire aged population. The persons not protected would be Federal employees who retired after July 1, 1960, and have had the opportunity to come under the liberal provisions of the Federal Employees Health Benefits Act of 1959. Others excluded would be aliens who have not been residents of the United States for 10 years and certain subversives.

Currently, 93 percent of the people reaching age 65 are eligible for benefits under social security or railroad retirement and this percentage will rise to close to 100 percent as the program matures. Thus, over the long run virtually all older people will earn entitlement for the proposed hospital insurance.

(*b*) *Benefits*

Persons entitled to benefits under the hospital insurance plan would be eligible to have payments made for inpatient hospital care and for important additional benefits covering posthospital extended care, posthospital home health services, and certain outpatient hospital diagnostic studies.

Benefits would be payable for covered hospital and related health services furnished beginning July 1, 1966. Posthospital extended care benefits would be effective January 1, 1967.

(*1*) *Inpatient hospital benefits*

The proposed inpatient hospital benefits would, except for a deductible amount, cover the cost of services provided by (or under arrangements with) participating hospitals (including tuberculosis hospitals, but not psychiatric hospitals—the latter would be covered under the voluntary supplementary plan) for up to 60 days in any one "spell of illness." A spell of illness would normally begin with the day a beneficiary enters a hospital and end after the beneficiary has remained out of a hospital and out of an extended care facility for 60 consecutive days.

If a person is in a tuberculosis hospital at the time be becomes entitled to benefits, the days he has already been in the hospital would count toward the 60-day limit on coverage of care in such a hospital during a spell of illness. This provision is in keeping with the intent of the basic plan to cover only the active phase of treatment and not to cover 60 days of care for a person who may have been institutionalized for years previously.

The deductible amount applicable to inpatient hospital services at the beginning of the program would be $40 per spell of illness. The deductible would be changed thereafter, but not before 1969, to keep pace with increases in hospital costs. Each year, beginning in 1968, the Secretary would determine the amount of the deductible applicable for the succeeding years on the basis of the relationship between the average amount paid per day for inpatient hospital services during the preceding year and the rate for 1966. Increases in the deductible amount would be made in $5 steps so that changes of a few cents or even of a few dollars would not have to be made immediately following each such change. However, over a period of time these changes would accurately reflect the changes in hospital costs. Small annual

changes would not only be an administrative problem, but they would also increase the problems of keeping beneficiaries informed of the applicable deductible.

Covered services.—The reasonable cost of service ordinarily provided to inpatients by hospitals (other than physician's services, and certain other items), including new services and techniques as they are adopted in the future, would be paid for. Services furnished to inpatients by others under arrangements with a hospital could also be covered if the arrangements call for billing for the services to be through the hospital exclusively. Since the reasonable cost of the services would be covered, hospitals would not be deterred, because of nonpaying or underpaying patients in this aged group, from trying to provide the best of modern care. The following are the major items and services that would be paid for.

Hospital room and board would be paid in full in accommodations containing from two to four beds. Payment would also be made for private accommodations where their use is medically indicated—ordinarily only when the patient's condition requires him to be isolated. Where private accommodations are furnished for the patient's comfort, the payments would cover only the equivalent of the reasonable cost of accommodations containing two to four beds; the patient would pay the extra charges for the private room.

Nursing services ordinarily furnished by hospitals would be paid for, but private duty nursing would not be covered.

Payments would not be made under the hospital insurance plan for the services of physicians, except services provided by interns and residents in training under approved teaching programs. Like other physicians' services, the services of radiologists, anesthesiologists, pathologists, and other physicians employed by the hospital or working through the hospital would be paid for under the voluntary supplementary plan; such services would not be covered under the hospital insurance plan. However, the services of the nonphysicians aiding such persons would be covered under the hospital insurance plan.

Drugs and biologicals furnished to hospital patients for their use while inpatients would be paid for. Payment would be provided for all drugs and biologicals which are listed in the United States Pharmacopoeia or National Formulary or New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or which are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing the drugs and biologicals. (These publications have been compiled and are maintained by the professional organizations concerned with the proper use of drugs.) The alternative requirement of approval by a committee of the medical staff of the hospital, is in line with the recommendations of the American Hospital Association, American Medical Association, American Pharmaceutical Association, and the American Society of Hospital Pharmacists. These organizations jointly have recommended that hospitals adopt a formulary system based upon the functioning of a pharmacy and drugs therapeutics committee of the medical staff of the hospital as a means of protecting the hospital's patients against drugs of poor quality. Innovation and the use of new drugs would not be discouraged because such hospital committee could adopt for use any new drugs which it approved.

The exception to the coverage of drugs and biologicals that are listed in the publications New Drugs or Accepted Dental Remedies is intended only to exclude the payment for drugs which have been unfavorably evaluated for all medicinal uses or for the medicinal use to which it is being put.

The intent of the provisions for determining which drugs and biologicals are covered is to permit payment for all drugs and biologicals which medical and medically related organizations have evaluated and selected as being proper for use in the course of good patient care.

There will be a deductible in an amount equal to the cost of the first 3 pints of blood furnished for an individual during a spell of illness. The difference between the cost of the blood to the hospital and the charge to the beneficiary would be deducted from the payments the proposed program would otherwise make to the hospital. Thus the hospital would not make a profit on the blood for which it charges a beneficiary. Your committee included this deduction provision in the interest of the voluntary blood replacement programs, which encourage donations of blood by waiving charges for blood which the patient arranges to replace. The limitation of the deduction to 3 pints of blood was made in view of the problems aged people would have in securing replacement of, or paying for, large quantities of blood.

Supplies and appliances would be paid for under the hospital insurance plan when they are a necessary part of the covered inpatient hospital services a patient receives. For example, the use of a wheelchair, crutches, or prosthetic appliances could be paid for as part of hospital services but payment for hospital services would not cover furnishing these items to the patient for use after his discharge. (However, the cost of using these items after hospitalization might be paid for if needed as part of the posthospital extended care he might receive or it might be provided under a plan for his home health services.) Items supplied at the request of the patient for his convenience, such as television rental in hospitals, would not be paid for under the program.

Conditions of participation.—Your committee's bill lists conditions that hospitals must meet in order to participate in the proposed program. These conditions for participation are included to provide assurance that participating institutions are safe, that they have facilities and organization necessary for the provision of adequate care, and that they exercise their responsibility to discourage improper and unnecessary utilization of their services and facilities. The inclusion of these conditions is designed to support the efforts of the various professional accrediting organizations sponsored by the medical and hospital associations, health insurance plans, and other interested parties to improve the quality of care in hospitals. To allow payments to institutions for services of lower quality than are now generally acceptable might reduce the incentive for establishing high-quality institutions or for maintaining high standards where they now exist.

In order to participate in the program, hospitals would be required to satisfy conditions specified in the bill relating to clinical records, medical staff bylaws, and utilization review. They would also have to meet certain other specified requirements. The bill authorizes the Secretary to prescribe such further requirements as the Secretary finds

45-399 O—65——3

necessary in the interest of health and safety. This authority is proposed because it would be inappropriate and unnecessary to include in the legislation all the precautions against fire hazards, contagion, etc., which should be required of institutions to make them safe. The health and safety requirements prescribed by the Secretary (including any requirements requested by a State which are higher than those prescribed for other States), cannot, however, be more strict than the comparable conditions prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals. Thus, the Secretary could, for example, require participating hospitals to maintain tissue committees which reexamine the condition of the organs removed during surgery and to meet other conditions which the health professions consider necessary to good patient care, but the Secretary could not set the hospital standards above the professionally established level.

Hospitals accredited by the Joint Commission on Accreditation of Hospitals would be conclusively presumed to meet all the conditions for participation, except for the requirement of utilization review. (If the Joint Commission adopts a requirement for utilization review, the Secretary could accept accreditation by the Joint Commission as sufficient evidence that a hospital meets all the requirements of the law.) Linking the conditions for participation to the requirements of the Joint Commission provides further assurance that only professionally established conditions would have to be met by providers of health services which seek to participate in the program.

The conditions of participation for tuberculosis hospitals would be similar to those for other hospitals, though differing in some respects due to their different purpose. To provide assurance that the program while paying for active treatment in tuberculosis hospitals would avoid paying for care that is merely custodial, the conditions of participation require that the hospital be accredited by the Joint Commission on Accreditation of Hospitals, that its clinical records be sufficient to permit the Secretary to determine the degree and intensity of treatment furnished to beneficiaries, and that it meet staffing requirements the Secretary finds necessary for carrying out an active treatment program. A distinct part of an institution can be considered a tuberculosis hospital if it meets the conditions even though the institution of which it is a part does not; and if the distinct part meets requirements equivalent to accreditation requirements, it could qualify under the program even though the institution is not accredited.

Your committee recognizes that there will be emergency situations where an individual who is eligible for hospital insurance benefits will go or be taken to a hospital that does not participate in the program. For example, an accident victim might have to be taken immediately to the nearest hospital, either for outpatient diagnosis and treatment or for admission as an inpatient. Your committee's bill would permit the payment of benefits for emergency hospital diagnostic services or inpatient care in such cases until it is no longer necessary from a medical standpoint to care for the patient in a nonparticipating institution. To be paid under the program for its services, the nonparticipating hospital, like participating hospitals, would have to agree not to charge the patient amounts (except the deductibles) in addition to the program's payments for covered services.

Christian Science sanatoriums that are operated or listed and certified by the First Church of Christ, Scientist, in Boston, could participate in the program as "hospitals." The participation of these institutions and the payment for items and services furnished by them would be subject to such conditions, limitations, and requirements as may be provided in regulations. In general, however, your committee intends that payments to Christian Science sanatoriums would cover costs of services ordinarily furnished by these sanatoriums to patients which are comparable to those for which payment could be made to hospitals and intends these sanatorium services to be a substitute for, and not an addition to, medical services that might be furnished to a person if his religious beliefs were not contrary to the use of the usual facilities. Coverages and exclusions applicable to hospital care would also apply in these institutions. For example, the services of a Christian Science nurse would be covered unless her duties are those of a private duty nurse or attendant; similarly, the services of a Christian Science practitioner, who is the Christian Science counterpart of the physician, would not be paid for since physician's services are not paid for under the hospital insurance plan. Payment would only be made for bedfast patients who, except for their religion, would have to have been admitted to a hospital.

(2) Posthospital extended care benefits

Care in an extended care facility will frequently represent the next appropriate step after the intensive care furnished in a hospital and will make unnecessary what might otherwise possibly be the continued occupancy of a high-cost hospital bed which is more appropriately used by acutely ill patients.

The posthospital extended care benefits which would be provided under the hospital insurance plan would cover care in qualified extended care facilities in cases where the patient was hospitalized for 3 or more consecutive days and then transferred to the facility for continued care of the same illness within 14 days of his hospital discharge. A patient who meets the hospital-transfer requirement and who is then discharged from the extended facility to his home could again receive extended care benefits in the same spell of illness without being hospitalized again if he is readmitted to the facility within 14 days after discharge. The hospital-transfer requirement is intended to help limit the payment of the extended care benefits to persons for whom such care may reasonably be presumed to be required in connection with continued treatment following inpatient hospital care and makes less likely unduly long hospital stays. This requirement also helps to assure that before a patient is admitted to an extended care facility his medical condition and needs will have been adequately medically appraised. Immediate transfer from a hospital to a posthospital extended care facility is not required because, in some instances, care in such a facility might be found to be needed, for example, only after a trial at convalescent care at the patient's home proves unsuccessful. Similarly, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to the facility.

Payments could be made for 20 days of care in extended care facilities plus, at the patient's option, 2 additional days of care for each day his hospital stay in a spell of illness is less than 60 days. The payments

would be made for extended care beyond the 20th day of the patient's stay in a facility unless he elects otherwise and his election would determine how many potential hospital days would be converted into extended care coverage and how many conserved for possible future need. However, no more than a total of 100 days of extended care benefits could be paid for during any one spell of illness. (The 20 basic days plus up to an additional 80 days as a result of the 2-for-1 formula.)

The number of days of inpatient hospital care for which payments could be made during a spell of illness would be reduced by 1 day for every 2 days of extended care above 20 for which payment is made.

Covered services.—The program would cover the items and services generally furnished by posthospital extended care facilities. These include room and board in two- to four-bed accommodations, nursing care, physical, occupational and speech therapy, and such drugs as are ordinarily furnished by the facility to its inpatients. In addition, payment could be made for the medical services of interns and residents in training and other diagnostic and therapeutic services furnished inpatients of the extended care facility by a hospital with which it has an agreement for the transfer of patients and exchange of medical records. Payment would also be made for physical, occupational, and speech therapy furnished by a party other than the facility if furnished under arrangements which provide for payment for therapy to be made through the facility. In no case could payment be made for any service, drug or other item which could not be paid for under the hospital insurance program if furnished in a hospital. Neither could payment be made for services not generally provided by posthospital extended care facilities. For example, under this rule the use of an operating room would not be covered in the case of an extended care facility since operating rooms are not generally maintained as part of such facilities.

Conditions for participation.—A posthospital extended care facility could be an institution, such as a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital or a section of a facility another part of which might serve as an old-age home. To assure that there will be no unnecessary barriers to the transfer of patients between hospital and extended care facilities when the attending physician determines the transfer is medically appropriate, a participating facility would be required (except as noted in the next paragraph) have an agreement with a hospital for the transfer of patients and interchange of medical records. The requirement of a transfer arrangement does not mean that a patient would have to be transferred between a hospital and extended care facility which have such an arrangement with each other in order to qualify for extended care benefits. A transfer arrangement with any hospital would qualify the facility so that a patient's posthospital extended care would be paid for if he was admitted from any hospital.

Where an extended care facility has attempted, in good faith, to arrange a transfer agreement with nearby hospitals, but failed, the State agency could waive the requirement for a transfer agreement if the agency finds that the facility's participation is in the public interest and essential to assuring extended care to older people in the particular community.

Extended care facilities would also be required to satisfy a number of conditions necessary for an institutional setting in which high-quality convalescent and rehabilitation care can be furnished. These include conditions relating to the provision of around-the-clock nursing services with at least one registered nurse employed full time, the availability of a physician to handle emergencies, the maintenance of appropriate medical policies governing the facility's skilled nursing care and related services, methods and procedures for handling drugs, and utilization review. In addition to the conditions specified in the bill, the Secretary would be authorized to prescribe such further requirements to safeguard the health and safety of beneficiaries as he may find necessary.

(*3*) *Posthospital home health care benefits*

Payments would be made for visiting nurse services and related home health services when furnished in accordance with a plan established and periodically reviewed by a physician. The proposed payments would be made only for a patient who is under the care of a physician and confined to his own home (except when he is taken elsewhere to receive services which cannot readily be supplied at home). Since the nature and extent of the care a patient would receive would be planned by a physician, medical supervision of the home health services furnished by paramedical personnel—such as nurses or physical therapists—would be assured.

Up to 100 visits by home health personnel would be paid for during a 1-year period following the patient's discharge from a hospital or extended care facility. To be eligible for home health benefits, the beneficiary would have to have been an inpatient in a hospital for at least 3 days or in an extended care facility and a home health plan for his care would have to be developed by a physician and steps would have to be taken to implement the plan within 14 days after his discharge.

A "visit" would be defined in regulations. It is contemplated, for example, that ordinarily one visit would be charged each time home health personnel furnish a covered service to the patient. For instance, a visit would be charged each time a therapist would go to the patient's home to furnish speech therapy. If a beneficiary had a visit from a speech therapist and a visiting nurse in the same day, two visits would be charged. Similarly, if the patient were to be taken to a hospital to receive outpatient therapy that could not be furnished in his own home—hydrotherapy, for example—and also received speech therapy and other services at the hospital in the course of the same visit, two or more visits might be charged.

Covered services.—The proposed posthospital home health payments would meet the cost of part-time or intermittent nursing services, physical, occupational, and speech therapy, and other related home health services furnished by visiting nurse agencies, hospital-based home health programs and similar agencies. More or less full-time nursing care would not be paid for under the home health benefits provision. Payments could be made for services furnished by other parties under arrangements with such agencies—the services of an independent physical therapist and interns and residents in training of an affiliated hospital, for example.

To the extent permitted in regulations, the part-time or intermittent services of a home health aide would also be covered. The duties of the home health aide which would be covered are comparable to those of a nurse's aide in the hospital who would have had training and experience that is not ordinarily possessed by lay people—for example, training and experience in giving bed baths to ill and bedfast patients. Often, the home health aide's services are essential if the patient is to be cared for outside a hospital or nursing facility. Food service arrangements, such as those of meals-on-wheels programs, or the services of housekeepers would not be paid for under the home health provisions.

While the home health patient would have to be homebound to be eligible for benefits, provision is made for the payment for services furnished at a hospital or extended care facility or rehabilitation center which requires the use of equipment that cannot ordinarily be taken to the patient in his home. In some cases special transportation arrangements may have to be made to bring the homebound patient to the institution providing these special services. The transportation itself would not be paid for. If he is furnished other services at the hospital or facility at the same time, these too could be paid for, even though they are of a kind that could be furnished in the patient's home. But such services would be covered only if they are furnished under arrangements which provide for billing through the home health agency. For example, if it is necessary, because of the size of the equipment involved, to take the patient to a hospital to give him physical therapy and while at the hospital he receives speech therapy, benefits could be paid for both services, but only if the home health agency takes responsibility for arranging and billing for all the services.

Conditions for participation.—The conditions for participation of home health agencies are designed primarily to assure that participating agencies are basically suppliers of health services. The proposal would cover visiting nurse organizations as well as agencies specifically established to provide a wide range of organized home health services. It would also cover home health services provided by a community hospital. In order to participate, the home health agency or organization would, in addition to meeting certain other requirements, either have to be publicly owned or be a nonprofit organization exempt from Federal taxation or it would have to be licensed and satisfy staffing requirements and other standards and conditions prescribed by regulation. It is the understanding of your committee that organizations providing organized home care on a profit basis are presently nonexistent. However, the language of the bill permits covering such agencies if they come into being, are licensed, and meet the high standards which the present nonprofit agencies offering organized care meet.

(*4*) *Outpatient hospital diagnostic benefits*

Finally, payment could be made for tests and related services—other than those performed by physicians—that are ordinarily furnished by a participating hospital to its outpatients for the purpose of diagnostic study. Payments could also be made for such service furnished by others under arrangements with the hospital that provide for the billing to be through the hospital. Where the services are furnished outside the hospital, they would have to be furnished in facilities

operated by or under the supervision of the hospital or its organized medical staff. (Diagnostic tests performed in a physician's office would, like other physicians' services, generally be covered under the voluntary supplementary plan unless part of a routine physical checkup.)

A deductible amount equal to one-half the deductible amount applicable in the case of inpatient hospital services would be applied against payments for outpatient hospital diagnostic services furnished by the same hospital during a 20-day period. The deductible would be $20 initially (½ of $40). If, within 20 days after receiving outpatient diagnostic services, the individual is hospitalized as an inpatient in the same hospital, the amount he paid for the outpatient diagnostic services (up to the amount of the outpatient deductible) would be credited against the inpatient deductible. Crediting the outpatient deductible in this way is intended to encourage the use of outpatient diagnostic tests rather than creating a situation where a patient would be inclined to insist on going into the hospital for the tests if he saw that he might, in the absence of this provision, have to pay this $20 deductible plus the $40 hospital deductible. Through this provision for correlating the deductibles the deductible amount to be paid by a hospitalized beneficiary would be the same whether the diagnostic tests are performed on a hospital inpatient or outpatient basis.

(*c*) *Method of payment*

The bill provides that the payment to hospitals and other providers of services shall be equal to the reasonable cost of the services and that the methods to be used and the items to be included in determining the cost shall be developed in regulations of the Secretary in accordance with the provisions of the bill. The regulations may provide for payment of the costs of services on a per diem, per unit, per capita, or other basis, may provide for the use of estimates in different circumstances, may provide for the use of estimates of cost of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the cost.

The appropriate basis of payment for hospital services when payment is made by public or private agencies has been the subject of extended and painstaking consideration for more than a decade. Governing principles have been developed which have attained a large measure of agreement. It is the intent of the bill that in framing regulations full advantage should be taken of the experience of private agencies in order that rates of payment to hospitals may be fair both to the institutions, to the contributors to the hospital insurance trust fund, and to other patients. In framing the regulations the Secretary and his staff will consult with the organizations that have developed these principles as well as with leading associations of providers of services.

Similar principles can without undue difficulty be developed to establish fair bases of payment to extended care facilities and home health services agencies.

The cost of hospital services varies widely from one hospital to another and the variations generally reflect differences in quality and intensity of care. The same thing is true with respect to the cost of the services of other providers. The provision in the bill for

payment of the reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another, except where a particular institution's costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization, and other relevant factors.

Although payment may be made on various bases the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services of individuals not covered will not be borne by the program. The basis for the computation of the cost of beneficiaries may vary by institution. The most usual hospital cost reimbursement procedures now in use by plans that pay for inpatient services are based on the average per diem cost of the patients in the institution to which payment is made, adjusted to reflect the provisions of the plan. Some institutions, however, base their charges to the public on careful cost ascertainment or accounting and change their charges only when there is a change in the cost of the service involved. In these and other appropriate cases reimbursement would be permitted on the basis of the ratio of cost to charges for the services actually received.

In other institutions some of the charges are set according to prevailing rates in the area, or are based on other considerations and not solely on the actual costs of the particular items and services rendered. Except where a close correlation of cost and charges would be shown, other methods would have to be applied to achieve equitable reimbursement.

The concept of reasonable cost and the principles and methods for translating this concept into practice in individual circumstances are of concern to consumers, providers of service, insuring organizations, and State and Federal governmental programs.

In the determination of reasonable costs of services consideration should be given to all necessary and proper expenses incurred in rendering the services, including normal standby costs. Reasonable costs should include appropriate treatment of depreciation on buildings and equipment (taking into account such factors as the effect of Hill-Burton construction grants and practices with respect to funding of depreciation) as well as necessary and proper interest on capital indebtedness.

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

Identifiable expenses for medical research, on the other hand, over and above the costs closely related to normal patient care, would not be met from the trust fund. Available research funds are generally ample to support important basic medical research.

In some cases, the charges hospital patients pay include a share of the cost of rendering services to free and part-pay patients as well as a share of uncollectible bills. Your committee has given careful consideration to the question of the effect that the proposed program would have on charges to other paying patients. The insurance system will reduce the losses of hospital income from bad debts or for care of free or part-pay aged patients which might otherwise be included in charges to other paying patients by paying the full cost, except for the deductible, for substantially all patients over 65. Under the public assistance programs now existing and even more as they would exist under the provisions of this bill, the Federal Government will make a very substantial contribution toward the medical care of the needy of all ages. Under the bill more of the needy could be aided under the Federal-State assistance programs. Further, the proposed amendments would require under the medical assistance and maternal and child health and crippled children programs of the Social Security Act the payment of the reasonable costs of covered hospital services. This will assist hospitals in reducing the income deficits arising out of providing hospital care to persons unable to pay for care.

These provisions, taken in combination with the hospital insurance system under part A of title XVIII, will appreciably reduce the need of hospitals to charge their paying and prepaying patients more than the cost of their services in order to compensate for care rendered to other patients without charge or at less than cost. The bill will thus make a contribution toward rationalizing the distribution of hospital costs and relieving voluntary insurance and prepayment systems, as well as those patients who pay for services at the time when they are rendered, of some part of the burden they now bear for indigent and charity patients.

In paying reasonable costs it is the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for costs actually incurred.

(*d*) *Financing*

The hospital insurance program would be financed through a separate payroll tax that would be paid by employees, employers, and the self-employed. The proceeds of this tax would be earmarked in a newly established hospital insurance trust fund, which means that these funds will be kept completely separate from the taxes which support the present social security program. The earnings base of the new tax would be the same base as that for the social security tax so that the recordkeeping tasks of employers and the Government would be left largely unaffected by the establishment of a separate contribution for hospital insurance. To assure that the hospital insurance contributions are clearly identified as such to contributors, the bill requires that the withholding forms, W–2's, show what proportion of the worker's total tax payment was withheld to finance the cost of the proposed hospital insurance. Hospital insurance benefits and administrative expenses would be paid only from the hospital insurance trust fund.

The complete separation of hospital insurance financing and benefit payments is intended to assure that the hospital insurance program will in no way impinge upon the financial soundness of the old-age, survivors, and disability insurance trust funds. A separate annual re-

port will be required on the operation of the hospital insurance program. Furthermore, identifying the contribution as a hospital insurance contribution will tend to increase the contributor's sense of financial responsibility for the benefits provided.

Under the proposed schedule of contribution rates, the fund would, be sufficient to cover all the costs of the hospital insurance benefits (and administration) for persons entitled to social security or railroad retirement benefits. The schedule of contribution rates is the same for employers, employees, and self-employed persons and is as follows:

	Percent		*Percent*
1966	0.35	1976–79	0.60
1967–72	.50	1980–86	.70
1973–75	.55	1987 and after	.80

As will be explained in greater detail later in this report, the schedule of contribution rates is based on conservative estimates of cost. The cost estimates also use the assumption that, while earnings will continue to rise in the future as they have in the past, the annual limitation on taxable earnings will not be increased beyond the last increase provided for in your committee's bill ($6,600 in 1971 and thereafter). If the earnings base is increased after 1971, the tax rates in the contribution schedule could be revised downward. In fact, if the earnings base does rise to keep up to date with the general earnings level, the steps in the contribution schedule beyond the vate of 0.55 percent would not be needed.

The cost of providing hospital and related posthospital insurance benefits to people who are not social security or railroad retirement beneficiaries would be met from general revenues.

2. VOLUNTARY SUPPLEMENTARY PLAN

(*a*) *Eligibility and enrollment under the voluntary supplementary plan*

The proposed supplementary health insurance would be available to all people age 65 and over (whether or not they are social security or railroad retirement beneficiaries) who are residents of the United States and either citizens or aliens admitted for permanent residence. Enrollment in the supplementary plan would be on a voluntary basis.

In general, an eligible person could enroll during the period beginning with the third month preceding the month in which he attains age 65 and ending 7 months later. The supplementary insurance would be effective with the first day of the third month following the month in which he enrolls (but not earlier than July 1, 1966). (If an eligible person enrolled in the first month of the 7-month period, his coverage would be effective with the month in which he reaches age 65.)

A special enrollment period would be available at the beginning of the program for people who have already reached 65 by December 31, 1965. This enrollment period would begin with the first day of the second month after the month in which the bill is enacted and end on March 31, 1966. Coverage under the supplementary insurance for people who enroll during this period would begin with July 1, 1966. Individuals who are eligible to enroll during this initial general enrollment period but fail to do so could enroll at any time before October 1, 1966, if the Secretary determines that there was good cause for the individual's failure to enroll. However, if an individual en-

rolls under the latter provision, his coverage could not begin until the sixth month after he enrolls. Monthly premiums would be collected for each month during which an individual was covered under the program.

There would be a general enrollment period between October 1 and December 31 of 1967 and during the comparable period in every odd-numbered year thereafter. A person who enrolls in a general enrollment period would get protection effective with the July 1 following the general enrollment period.

No one could enroll for the first time more than 3 years after the close of the first enrollment period open to him and no one could reenroll unless he does so in a general enrollment period which begins within 3 years of the date his previous enrollment was terminated. A person could reenroll only once.

The limitations on enrollment and reenrollment such as those recommended are made in order to reduce the possibility of people enrolling in the program when their health deteriorates, thus increasing costs by covering people during periods of ill health who chose not to be covered during periods of good health.

The Secretary also is authorized to enter into an agreement with any State which, before July 1, 1967, elects to have certain of its money payment recipients covered by the supplementary plan. States would be permitted to decide whether to request enrollment of the money payment recipients of OAA or such recipients who are 65 years of age and older who are receiving money payments under the combined program, title XVI, or to decide to request coverage for all the aged among the money payment recipients under titles I, IV, X, XIV, and XVI. Excluded from coverage under this arrangement are those persons who are entitled to receive a benefit under the old-age, survivors, and disability insurance system, or the Railroad Retirement Act. The State would pay, in behalf of each individual who is to be enrolled, the premium charge that is determined by the provisions of the bill. Those recipients of public assistance money payments who become 65 years of age on or after July 1, 1967, and who are eligible to enroll individually may have their monthly premium charges paid by the public assistance agency with Federal financial participation. However, your committee believes that it is not practicable at this time to authorize States to cover recipients of medical assistance for the aged through vendor payments under an agreement or to make premium payments in their behalf.

The bill provides that under certain circumstances, the State public welfare agency may act as the carrier in the State for the administration of those provisions with respect to individuals who are receiving money payments under public assistance programs, whether such individuals are covered by the agreement or not.

The agreement may also include provisions for transfer of public assistance funds to another carrier, if the State is not serving as a carrier, so that the insurance benefits and deductibles, coinsurance, and other items met by the State under its public assistance plans can be merged for purposes of paying providers of medical care.

(*b*) *Benefits under the voluntary supplementary plan*

The voluntary supplementary plan would provide protection that builds upon the protection provided by the hospital insurance plan. It

would cover physicians' services, additional home health visits, care in psychiatric hospitals and a variety of medical and other services not covered under the hospital insurance plan. The beneficiary would pay the first $50 of expenses he incurs each year for services of the type covered under the plan. Above this deductible amount, the plan would pay 80 percent of the reasonable costs in the case of services provided by an institution or home health agency and 80 percent of reasonable charges for other covered services, with 20 percent being paid by the beneficiary.

Benefits under the supplementary plan would be provided for:

(1) Physicians' services, including surgery, consultation, and home, office, and institutional calls.

(2) Medical and other health services. These would include:

(*a*) Diagnostic X-ray and laboratory tests and other diagnostic tests;

(*b*) X-ray, radium, and radioactive isotope therapy;

(*c*) Surgical dressings, splints, casts, and other devices for reduction of fractures and dislocations;

(*d*) Rental of durable medical equipment, such as iron lungs, oxygen tents, hospital beds, and wheelchairs;

(*e*) Prosthetic devices (other than dental) which replace all or part of an internal body organ;

(*f*) Ambulance services with limitations;

(*g*) Braces and artificial legs, arms, and eyes.

(3) Inpatient psychiatric hospital services for up to 60 days during a spell of illness (subject to a lifetime maximum of 180 days).

(4) Home health services for up to 100 visits during a calendar year (without a requirement of prior hospitalization).

The $50 deductible would be applied on a calendar year basis, except that expenses the individual incurred in the last 3 months of the preceding calendar year would be counted as satisfying the deductible if they had been counted toward the deductible in that year. This special carryover provision would avoid requiring persons with substantial costs at the end of 1 year to meet the deductible perhaps early in the next year as though they had had no prior bills.

There would be a special limitation on benefits for expenses in connection with treatment of mental, psychoneurotic, and personality disorders of a person who is not a hospital inpatient. During any year, a maximum of $312.50 or 62½ percent of the expenses involved, whichever is smaller, would be considered incurred expenses—that is, expenses used in calculating benefit payments. The effect of this provision is to limit payment under the plan to a maximum of $250 (80 percent of $312.50) or half of the incurred expense (80 percent of 62½ percent of the expense), whichever is less.

Expenses for the first 3 pints of blood furnished a person in a psychiatric hospital during a spell of illness would not be considered incurred expenses (for which the program could make payment) unless the individual had already received 3 pints of blood which was not paid for under the hospital insurance plan because of the similar exclusion under that plan.

Ambulance services would be covered only where other methods of transportation are not feasible due to the individual's condition, and only to the extent provided in regulations. It is the intention of your

committee that transportation by ambulance be covered only if (*a*) normal transportation would endanger the health of the patient and (*b*) the individual is transported to the nearest hospital with appropriate facilities or to one in the same locality, and under similar restrictions, from one hospital to another, to the patient's home or to an extended care facility.

If a person is in a psychiatric hospital at the time he becomes entitled to benefits, the days he has already been in the hospital would count toward the 60-day limit on coverage of care in such a hospital during a spell of illness, but they would not count toward the 180-day lifetime limit. This provision is in keeping with the intent of the plan to cover only the active phase of treatment of mental illness and not to cover 60 days of care for a person who may have been institutionalized for years previously. The services covered under the supplementary plan as inpatient psychiatric hospital services would generally be the same as the services that are covered as inpatient hospital services under the hospital insurance plan.

The conditions of participation for psychiatric hospitals would be similar to those for other hospitals, though differing in some respects. To provide assurance that the supplementary plan, while paying for active treatment in psychiatric hospitals, would avoid paying for care that is merely custodial, the conditions of participation require that the hospital be accredited by the Joint Commission on Accreditation of Hospitals, that its clinical records be sufficient to permit the Secretary to determine the degree and intensity of treatment furnished to beneficiaries, and that it meet staffing requirements the Secretary finds necessary for carrying out an active treatment program. A distinct part of an institution can be considered a psychiatric hospital if it meets the conditions even though the institution of which it is a part does not; and if the distinct part meets requirements equivalent to accreditation requirements, it could qualify under the program even though the institution is not accredited. For inpatient psychiatric hospital services, the certification required of physicians would be appropriate to the condition being treated and somewhat different from that for inpatient hospital services under the hospital insurance program.

Covered home health services and the conditions of participation for home health agencies would be the same as under the hospital insurance plan. There would, however, be no requirement, as there is in the hospital insurance plan, that benefits be paid only when the patient was previously hospitalized.

(*c*) *Method of payment under the voluntary supplementary plan*

After the individual has incurred the $50 deductible amount, the plan would pay 80 percent of the reasonable costs of or the reasonable charges for the covered services. In the case of services (other than physicians' services) furnished by, or under arrangements made by, hospitals, extended care facilities, and home health agencies, payment would be 80 percent of reasonable costs and would be made to the provider of services by the carrier administering the benefits under the supplementary plan. In all other cases, payment would be 80 percent of reasonable charges and would be made by the carrier to the beneficiary unless the beneficiary assigned the benefits to the person or organization which furnished the covered services.

Reasonable cost, as defined for purposes of reimbursement under the supplementary plan, would be the same as under the hospital insurance plan. The carriers administering the benefits under the supplementary plan would, under the terms of their contracts with the Secretary, have to take such action as may be necessary to assure that where payment is on a cost basis, the cost is reasonable cost. In general, under the supplementary plan a provider of services (a covered hospital, extended care facility, or home health agency) could charge a beneficiary the $50 deductible and 20 percent of the reasonable charges (in excess of the $50 deductible) for the covered services.

Where payment by the program is on the basis of charges (for physicians' services and medical and other health services not furnished by providers of services), the carriers would take action to assure that the charge on which the reimbursement is based is reasonable and is not higher than the charge used for reimbursement on behalf of the carriers' own policyholders or subscribers for comparable services and under comparable circumstances. In addition, where payment is on the basis of an assignment, the reasonable charge would have to be accepted as the full payment. In determining reasonable charges, the carriers would consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services.

(*d*) *Financing*

Your committee's bill establishes a premium of $3 a month initially for individuals who enroll under the supplementary plan. Since the minimum increase in cash social security benefits provided under the bill for retired workers 65 and over would be $4 a month ($6 a month for man and wife who are both 65 and are receiving benefits based on the same earnings record), the minimum benefit increase would fully cover the amount of monthly premiums for the supplementary plan. Persons enrolling who are entitled to monthly social security or railroad retirement benefits would have the premiums deducted from their monthly benefits. (Of course, enrollment in the plan is voluntary.) Deducting the premium from monthly benefits would help keep collection costs to a minimum. The method of collecting premiums for those who are not entitled to monthly benefits would be prescribed by the Secretary. People who are entitled to monthly benefits but who, because they have not retired, may not actually receive them or those who may receive only a part of them could estimate the amount by which premiums will exceed the amount of their benefits and could pay in advance the required additional amount to the Secretary. If advance payment is not made in these cases, the annual calculation of adjustment in benefits needed where a beneficiary has worked in the prior year would take into account the premiums owed and paid in connection with the supplementary plan.

Provision is made for the Secretary to adjust the premium amounts supporting the program if medical or other costs rise, but there would be no increase in premiums before 1968, and increases would be made not more often than every 2 years after 1968. To take into account the higher cost of insuring an older individual, premiums payable by a person who enrolled later than the first period when enrollment was open to him or who reenrolled after his enrollment was terminated

would be increased by 10 percent for each full year he could have been but was not enrolled.

There would be a contribution from Federal general revenues equal to the aggregate premiums payable by enrollees. In addition, funds could be appropriated in fiscal year 1966 and remain available through the next fiscal year as repayable advances (without interest) to the trust fund in order to provide an operating fund at the beginning of the program and to provide a contingency reserve. The maximum that could be appropriated for this purpose would be $18 per person eligible to enroll at the beginning of the supplementary program, July 1, 1966.

A new separate trust fund would be established—the Federal Supplementary Health Insurance Benefits Trust Fund. All premiums and Government contributions for the supplementary program would be paid into the fund and all benefits and administrative expenses would be paid from the fund.

3. GENERAL PROVISIONS RELATING TO THE BASIC AND VOLUNTARY SUPPLEMENTARY PLANS

(a) *Conditions and limitations on payment for services*

(1) *Physicians' role*

Your committee's bill provides that the physician is to be the key figure in determining utilization of health services—and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the bill would require that payment could be made only if a physician certifies to the medical necessity of the services furnished. If services are furnished over a period of time to be specified in regulations, recertification by the physician would be necessary. Delayed physician certifications and recertifications, accompanied by medical and other evidence, to the extent provided by regulations, could be accepted in lieu of timely certifications and recertifications when, for example, the patient was unaware of his eligibility for the benefits when he was treated.

In the case of inpatient hospital services for which payment would be made, the bill would require that a physician certify that the services were required for an individual's medical treatment, or that inpatient diagnostic study was medically required and that the services were necessary for such purpose. The first physician recertification in each case of inpatient hospital services furnished over a period of time would be required no later than the 20th day of the period. In the case of outpatient hospital diagnostic services, a physician would have to certify that the services were required for diagnostic study.

In the case of posthospital extended care a physician would have to certify that the care was required because the individual needed skilled nursing care on a continuing basis for a condition with respect to which he was receiving inpatient hospital services prior to transfer to the extended care facility or for a condition which arose after such transfer and while the individual was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services.

In the case of home health services, a physician would have to certify that the services were required because the individual was confined

to his home. He would also have to certify that the individual needed (except for receipt of special treatment at a medical institution) skilled nursing care on an intermittent basis or physical or speech therapy. In the case of home health services, the intermittent nursing care or the physical or speech therapy would have to be for treatment of a condition for which the individual had received inpatient hospital services or posthospital extended care.

Your committee recognizes that there often is a significant difference between treatment provided in mental and tuberculosis hospitals and the treatment provided in other hospitals. Often the care in such institutions is purely custodial and it is the intent of the bill to cover only active care intended to cure patients in such hospitals and not to cover custodial care. Therefore, the bill would require that a physician make specific certifications before payment could be made for inpatient hospital services furnished in either a psychiatric hospital or a tuberculosis hospital. In the case of inpatient hospital services furnished in a psychiatric hospital for the psychiatric treatment of an individual, a physician would have to certify that the psychiatric services could reasonably be expected to improve the condition for which the treatment was necessary or that inpatient diagnostic study was medically required and inpatient psychiatric hospital services were necessary for such purposes. In the case of inpatient tuberculosis hospital services a physician would have to certify that the services were required to be given on an inpatient basis for the treatment of an individual for tuberculosis and that the treatment could reasonably be expected to either improve the condition for which the treatment was necessary or render the condition noncommunicable.

(2) Utilization review

The provisions of your committee's bill with respect to mechanisms for the review of utilization of services follow the kind of recommendations for utilization review that have been made by private study groups, State and national medical societies, and State agencies.

Hospitals and extended care facilities participating in the program would be required to have in effect a utilization review plan providing for a review of admissions to the institution, length of stays, and the medical necessity for services provided with the objective of promoting the efficient use of services and facilities. The review would ordinarily be carried out by a staff committee of the institution, which would have to include two or more physicians but which could also include other professional personnel such as registered nurses and medical social workers. Alternatively, the review could be conducted by a similar group outside the institution—preferably one established by the local medical society and some or all of the hospitals and extended care facilities in the locality. In some circumstances the review committee would have to be one outside the institution—for example, where the small size of the institution or, in the case of an extended care facility, the lack of an organized medical staff makes it impracticable for the institution to have a properly functioning staff committee. As mentioned previously, if and when the Joint Commission on the Accreditation of Hospitals adopts a utilization review requirement for accreditation, the Secretary could accept accreditation by the Joint Commission as sufficient evidence that a hospital meets the requirements of the law.

Under a utilization review plan, timely review would have to be made of each case in which a beneficiary stays in the institution for an extended period. Regulations would provide the institution some leeway in determining when the review would have to be carried out, and the point at which a review would be most appropriate might vary with the diagnosis and treatment involved. Where timely reviews are not being made, the Secretary could, in lieu of terminating the agreement under which the institution participates in the program, make a decision that with respect to that institution the program would make payment only for the first 20 days of a beneficiary's stay in the case of a hospital, or only for days up to a specified number (to be specified in regulations) in the case of an extended care facility.

The attending physician would have to be offered an opportunity for consultation before there could be a finding that a beneficiary's further stay in the institution is not medically necessary, by the physician members of the review group; and the individual, the institution and the attending physician would have to be promptly notified of any such finding. Where such a finding has been made, the program could not make payment for services furnished the patient after the third day following the day on which the institution received notice of the finding.

Under your committee's bill, various organizations participating in the administration of the program could have a role in facilitating utilization review. State agencies could provide consultative services to assist in the establishment of utilization review procedures and in evaluating their effectiveness. Under the hospital insurance plan, public or private organizations nominated by providers must assist in the application of safeguards against unnecessary utilization. Carriers administering benefits under the voluntary supplementary plan would determine compliance with the utilization review requirement; assist in the establishment of review groups outside hospitals; assist hospitals, extended care facilities and others who furnish covered services to develop procedures relating to utilization practices; and make studies of such procedures and methods for their improvement.

(*b*) *Exclusions from coverage*

Your committee's bill would exclude certain health items and services from coverage under both the hospital insurance and the voluntary supplementary health insurance programs in addition to any excluded through the operation of other provisions of the bill. For example, the bill would bar payment for health items or services that are not reasonable and necessary for the treatment of illness or injury or to improve the functioning of a malformed body member. Thus, payment could be made for the rental of a special hospital bed to be used by a patient in his home only if it was a reasonable and necessary part of a sick person's treatment. Similarly, such potential personal comfort items and services as massages and heat lamp treatments would only be covered where they contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Expenses for custodial care would also be excluded.

The proposed insurance programs would not pay for any item or service furnished an individual if neither the individual nor any other person (such as a prepayment plan) has a legal obligation to pay

for or provide the services. (Under the provision, the third-party liability statute 42 U.S.C. 2651–2653 would not apply.) Free chest X-rays provided by health organizations, for example, would not be covered. Where health expenses are charged the patient by a member of the patient's household or by an immediate relative, no payment would be made. However, a person of little means would not be barred from payment under the insurance programs because he met the test of medical indigency and was otherwise eligible to receive medical assistance under a public assistance program. Furthermore, if a person received his care on some prearranged basis toward which he prepaid, the program provided for under the title would nevertheless pay its benefits in full. Your committee expects that the patient's prepayment arrangement would be adjusted appropriately in consideration of the fact that the program met part of the patient's health costs. Except in such cases as the Secretary may specify, no payment would be made for items and services which are paid for directly or indirectly by a governmental entity.

Payments would only be made for items and services provided in the United States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. Payment would not be made for items and services required as a result of war or an act of war which occurs after the effective date of the individual's coverage under the proposed insurance.

Payments would not be made for routine physical examinations or for eyeglasses, hearing aids or the fitting expenses or other costs incurred in connection with their purchase. Thus, payment would be made under the supplementary plan for the physician's services connected with the diagnosis of a specific complaint and the treatment of the ailment, but a routine annual or semiannual checkup would not be covered. Similarly, the diagnosis and treatment by an ophthalmologist of, say, cataracts would be covered but the expenses of an eye examination to determine the need for eyeglasses and charges for prescribing and fitting eyeglasses or contact lenses would not be covered. Neither would payment be made for orthopedic shoes or other supportive devices for the feet.

Expenses for cosmetic surgery would not be covered except where incurred in connection with the prompt repair of an accidental injury or to improve the functioning of a malformed body member. For example, cosmetic surgery could be paid for when furnished in connection with the treatment of a severely burned person.

Payment would not be made for health items and services to the extent that payments have been made, or can reasonably be expected to be made, for them under a workmen's compensation law. The Secretary would prescribe regulations to govern the making of payments where a beneficiary's status under workmen's compensation has not been ascertained. Payment would be made under the insurance plans on the condition that repayment would be made if information is received that a workmen's compensation payment for the health care has been made.

(*c*) *Administration of health insurance provisions*

Overall responsibility for administration of the hospital insurance and voluntary supplementary health insurance programs would rest with the Secretary of Health, Education, and Welfare, but State

agencies and private organizations operating under agreements with the Secretary and private carriers or public organizations operating under contracts with the Secretary would have a major administrative role. In addition to using such organizations under the conditions described below, the Secretary would be authorized to purchase or contract separately for services such as auditing or cost analysis.

(1) Advisory and review groups

Your committee's bill provides for the establishment of a Health Insurance Benefits Advisory Council to advise the Secretary on general administrative policy matters and on the formulation of regulations in connection with the hospital insurance program and supplementary health insurance program, including regulations relating to conditions of participation for providers. The Advisory Council, appointed by the Secretary, would consist of a chairman and 15 members including persons outstanding in hospital, medical, and other health activities and at least one representative of the public. The members could not include regular Federal Government employees.

The bill also provides for the establishment of a National Medical Review Committee to study the utilization of hospital and other medical care and services with a view to recommending changes in the way covered care and services are used and in the administration of the basic and supplemental plans.

The committee is required to make an annual report of its recommendations to the Secretary, and he is required to transmit the report to the Congress.

The committee is to be composed of nine persons, one of whom the Secretary would designate as chairman. The members are to be selected from people who are representative of organizations and associations of professional people in the field of medicine and other people who are outstanding in the field of medicine or related fields and a majority of the committee are to be physicians and at least one member will represent the general public. Regular Federal Government employees could not be members of the committee.

(2) Conditions of participation

In formulating specific conditions of participation necessary for health and safety, the Secretary would consult with appropriate governmental agencies and private organizations. The bill specifically requires consultation with appropriate State and local agencies and national listing or accrediting bodies. Your committee would expect that the Secretary would consult with the Joint Commission on the Accreditation of Hospitals as well as with associations of providers of services. Such consultations should be helpful in the development of policies, operational procedures and administrative arrangements of mutual satisfaction to all parties interested in the basic and supplementary plans. Such consultation would provide additional assurance that varying conditions of local and national significance are taken into account.

(3) Agreements to participate

An eligible hospital, extended care facility or home health agency could participate in the programs if it filed with the Secretary an agreement not to charge any beneficiary for covered services for which

payment would be made under the program and to make adequate provision for refund of erroneous charges. Of course, a provider could bill a beneficiary for deductible and coinsurance amounts, for the first 3 pints of blood furnished him during a spell of illness, and for the portion of the charge for a private room or services supplied at the patient's request and not paid for under the program.

An agreement could be terminated by either the provider of services or the Secretary of Health, Education, and Welfare. Beneficiaries would be protected from an abrupt termination of an agreement by a provider by the requirement that notice must be given by the provider to the Secretary and to the public. The length of time between the notice and the point at which the termination becomes effective may be specified in regulations (but the length of time cannot be longer than 6 months).

The Secretary could terminate an agreement only after reasonable notice and only if the provider (*a*) does not comply with the provisions of the agreement or of the law and regulations, (*b*) is no longer eligible to participate, or (*c*) fails to provide data needed to determine what benefit amounts are payable or refuses access to financial records for verification of bills. The Secretary would be required to give reasonable notice and opportunity for hearing to a provider of services before making a final determination that the provider does not qualify to participate under the program or before terminating an agreement with the provider. The final administrative decision is subject to judicial review.

(*4*) *Role of the States*

Your committee's bill provides for State agencies, operating under an agreement with the Secretary, to determine whether a provider of services—a hospital, extended care facility or home health agency—meets the conditions for participation in the program, and having determined that the provider meets the conditions, to certify the fact to the Secretary. The Secretary would be required to use the services of State health departments or other appropriate State or local agencies in this way wherever the State agency is able and willing to perform this administrative function. In addition, the Secretary would be authorized to use such agencies for the following additional functions:

(*a*) Rendering consultative services to providers to assist them to establish and maintain necessary fiscal records and otherwise to meet the conditions for participation and to provide information necessary to derive operating costs so as to determine amounts to be paid for the providers' services;

(*b*) Rendering consultative services to providers and medical societies to assist in the establishment and testing of utilization review procedures.

To illustrate a consultative function a State agency could perform to assist providers to qualify, a State agency could assist an extended care facility to establish a transfer agreement with a participating hospital.

The Secretary could select also either public or private organizations participating in administration of the programs to perform the consultative functions mentioned in (*a*) and (*b*), above. This would enable him to select the organization which he finds can most capably carry out these functions in the specific situation.

State agencies would be reimbursed for the costs of activities they perform in the program. As in the cooperative arrangements with State agencies in the social security disability program, reimbursement to State agencies for hospital insurance benefits activities would meet the agency's related costs of administrative overhead as well as of staff. In recognition of the need for coordination of the various programs in the States that have to do with payment for health care, quality of care, and the distribution of health services and facilities, the Federal Hospital Insurance Trust Fund would pay a fair share of the State agency's costs attributable to planning and coordination of the functions to be performed under the terms of the agreements, with those other activities for which the agency is responsible which relate to public and private programs for the provision of health services similar to those for which payment may be made under the proposed program.

(5) *Role of public or private organizations*

Your committee's bill provides a considerable role for the participation of private organizations in the administration of both the hospital insurance plan and the supplementary plan.

Under the hospital insurance plan, groups of providers, or associations of providers on behalf of their members, could nominate a national, State, or other public or private agency or organization which they wished to have serve as a fiscal intermediary between themselves and the Federal Government. While it is expected that most providers would want to nominate a private organization, the bill would also permit nomination of a public agency (a State public health agency, for example) by providers which wished to have such an agency serve as fiscal intermediary.

A member of an association whose nominated organization or agency had been selected as a fiscal intermediary could elect to receive payment from another intermediary which had been selected (provided that the other organization or agency agrees) or could elect to deal directly with the Secretary.

The organization or agency serving as a fiscal intermediary under Part A would, under agreement with the Secetary, determine the amount of payments due upon presentation of provider bills and make the payments. The Secretary would be permitted to enter into agreement with a nominated organization only if he finds that this would be consistent with effective and efficient administration and that the organization is able and willing to assist in the application of safeguards against unnecessary utilization of covered services, and only if the organization agrees to furnish him with such of the information it gathers in carrying out the agreement as he finds necessary. The agreement may include provision for the agency or organization to perform one or more of certain administrative duties other than the payment function. These would include providing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise to qualify as providers of services, serving as a center for communicating with providers, making audits of provider records, and performing related functions. The Government would provide advances of funds to the agencies or organizations for purposes of benefit payments and as a working fund for administrative expenses, subject to account and settlement on a cost-incurred basis.

Your committee believes that benefits under the supplementary health insurance benefits program in Part B should be administered by the private sector. This form of administration is particularly appropriate for the supplementary plan because of the benefits the plan would provide in the case of physicians' services. Private insurers, group health plans, and voluntary medical insurance plans have great experience in reimbursing physicians.

The bill requires the Secretary, to the extent possible, to enter into contracts with carriers under which the carriers would perform specified administrative functions or, to the extent provided in the contracts, secure the performance of these functions by other organizations. These functions include: Determining the amount of payments due providers, and making the payments; auditing records of providers; determining whether providers meet the utilization review requirements under the program; assisting providers to develop procedures relating to utilization practices, and studying the effectiveness of such procedures; assisting in the application of safeguards against unnecessary utilization of covered services and in the establishment of review groups outside hospitals; serving as a channel of communication of information relating to the program's administration; and otherwise assisting in the administration of the supplementary plan.

The Secretary would be permitted to enter into contracts with carriers without regard to provisions of law relating to competitive bidding. However, he could enter into such a contract only if he found that the carrier would perform efficiently and effectively and if the carrier met such requirements as to financial responsibility, legal authority, and such other matters as the Secretary found pertinent. It is your committee's intent that the Secretary shall, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance. The contracts would have to provide that the carrier would take action to assure that the charges and costs of services for which the supplementary plan may make payment are reasonable. The carrier would also have to maintain such records and furnish such information and reports as the Secretary finds necessary and, in addition, would have to establish procedures for fair review of beneficiary complaints regarding disallowed requests for payment and requests where the amount of payment is in controversy.

The contracts would be for a term of at least 1 year, and could be made automatically renewable. A contract would provide for payment of the carrier's cost of administration (including advances of funds for such purposes), as the Secretary determined to be necessary and proper for carrying out the functions covered by the contract. The Secretary could terminate a contract, after reasonable notice and opportunity for a hearing, if he found that the carrier had failed to substantially carry out the contract or was carrying it out in a manner inconsistent with the efficient administration of the supplementary health insurance program.

The bill broadly defines a carrier with which the Secretary could contract as a voluntary association, corporation, partnership, or other nongovernmental organization lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance

policies or contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier. The definition would specifically include a health benefits plan duly sponsored or underwritten by an employee organization. With respect to hospitals, extended care facilities, and home health agencies, the definition also includes a public or private organization which is nominated by providers of services and which participates in administration of the hospital insurance plan. In addition, a State welfare agency which buys into the program for aged welfare recipients could act as the carrier for its recipients (if it met the other conditions of participitation as a carrier).

(6) *Appeals*

Your committee's bill provides for the Secretary to make determinations, under both the hospital insurance plan and the supplementary plan, as to whether individuals are entitled to hospital insurance benefits or supplementary health insurance benefits and for hearings by the Secretary and judicial review where an individual is dissatisfied with the Secretary's determination. Hearings and judicial review are also provided for where an individual is dissatisfied with a determination as to the amount of benefits under the hospital insurance plan if the amount in controversy is $1,000 or more. (Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits.) Hospitals, extended care facilities, and home health agencies would be entitled to hearing and judicial review if they are dissatisfied with the Secretary's determination regarding their eligibility to participate in the program.

4. ACTUARIAL COST ESTIMATES FOR THE HOSPITAL INSURANCE SYSTEM

(a) *Summary of actuarial cost estimates*

The hospital insurance system established by your committee's bill has an estimated cost for benefit payments and administrative expenses that is in long-range balance with contribution income. It is recognized that the preparation of cost estimates for hospitalization and related benefits is much more difficult and is much more subject to variation than cost estimates for the cash benefits of the old-age, survivors, and disability insurance system. This is so not only because the hospital insurance program would be newly established, with no past operating experience, but also because of the greater number of variable factors involved in a service-benefit program than in a cash-benefit one. However, your committee believes that the cost estimates are made under very conservative assumptions with respect to all forseeable factors.

It is essential, in the view of your committee, that the developing operations of this new program should be carefully studied as they occur in the immediate future, so that the Congress and the executive branch can be kept as well informed as possible and as quickly as is feasible. Under these circumstances, your committee agrees with the suggestion which has been made that there should be a small continuing actuarial sample (of perhaps 0.1 percent of all eligible individuals), whose experience can be followed as promptly and as thoroughly as if the system related to only about 20,000 persons (under which circumstances, it would be possible to make many complete studies

of experience as rapidly as it develops, without the disadvantages from a time standpoint of handling the vast amount of data that arises for the millions of persons protected by the full program). In this connection, it will be essential for carriers involved in the processing and payment of claims to supply the necessary actuarial information promptly and in adequate fashion for the actuarial analyses to be made.

(*b*) *Financing policy*

(*1*) *Financing basis of committee bill*

The contribution schedule contained in your committee's bill for the hospital insurance program and the corresponding maximum earnings bases are as follows:

Calendar year	Earnings base	Employer-employee rate (percent)	Self-employed rate (percent)
1966	$5,600	0.7	0.35
1967 to 1970	5,600	1.0	.50
1971 to 1972	6,600	1.0	.50
1973 to 1975	6,600	1.1	.55
1976 to 1979	6,600	1.2	.60
1980 to 1986	6,600	1.4	.70
1987 and after	6,600	1.6	.80

The hospital insurance program would be completely separate from the old-age, survivors, and disability insurance system in several ways, although the earnings base would be the same under both programs. *First*, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where there is a single tax rate for both programs, but an allocation thereof into two portions). *Second*, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate Board of Trustees from that of the old-age, survivors, and disability insurance system. *Third*, the bill provides that income tax withholding statements (forms W–2) shall show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter. *Fourth*, the hospital insurance program would cover railroad employees directly in the same manner as other covered workers, and their contributions would go directly into the hospital insurance trust fund and their benefit payments would be paid directly from this trust fund (rather than directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions). *Fifth*, the financing basis for the hospital insurance system would be determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one).

(2) Self-supporting nature of system

Just as has always been the case in connection with the old-age, survivors, and disability insurance system, your committee has very carefully considered the cost aspects of the proposed hospital insurance system. In the same manner, your committee believes that this program should be completely self-supporting from the contributions of covered individuals and employers (the transitional uninsured group that would be covered by this program would have their benefits, and the resulting administrative expenses, completely financed from general revenues, according to the provisions of the bill). Accordingly, your committee very strongly believes that the tax schedule in the law should make the hospital insurance system self-supporting over the long range as nearly as can be foreseen, as well as actuarially sound.

(3) Actuarial soundness of system

The concept of actuarial soundness as it applies to the hospital insurance system is somewhat similar to that concept as it applies to the old-age, survivors, and disability insurance system (see discussion of this topic in a following section), but there are important differences.

One major difference in this concept as it applies between the two different systems is that cost estimates for the hospital insurance program should desirably be made over a period of only 25 years in the future, rather than 75 years as in connection with the old-age, survivors, and disability insurance program. A shorter period for the hospital insurance program is necessary because of the greater difficulty in making forecast assumptions for a service benefit than for a cash benefit. Although there is reasonable likelihood that the number of beneficiaries aged 65 and over will tend to increase over the next 75 years when measured relative to covered population (so that a period of this length is both necessary and desirable for studying the cost of the cash benefits under the old-age, survivors, and disability insurance program), it is far more difficult to make reasonable assumptions as to the trends of medical care costs and practices for more than 25 years in the future.

In starting a new program such as hospital insurance, it seems desirable to your committee that the program should be completely in actuarial balance. In order to accomplish this result, your committee has developed a contribution schedule that will meet this requirement, according to the underlying cost estimates.

(c) Hospitalization data and assumptions

(1) Past increases in hospital costs and in earnings

Table A presents a summary comparison of the annual increases in hospital costs and the corresponding increases in wages that have occurred since 1954 and up through 1963.

TABLE I.—*Comparison of annual increases in hospitalization costs and in earnings*

[In percent]

Calendar year	Increase over previous year	
	Average wages in covered employment	Average daily hospitalization costs
1955	3.8	6.3
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
Average [1]	4.0	6.7

[1] Rate of increase compounded annually that is equivalent to total relative increase from 1954 to 1963.

The annual increases in earnings are based on those in covered employment under the old-age, survivors, and disability insurance system as indicated by first quarter taxable wages, which by and large are not affected by the maximum taxable earnings base. The data on increases in hospitalization costs are based on a series of average daily costs (including not only room and board, but also other charges), prepared by the American Hospital Association.

The annual increases in earnings have fluctuated somewhat over the 10-year period, although there have not been very large deviations from the average annual rate of 4.0 percent; no upward or downward trend over the period is discernible. The annual increases in hospital costs likewise have fluctuated from year to year around the average annual rate of 6.7 percent; the increases in the last 2 years were relatively low as compared with previous years.

Hospital costs then have been increasing at a faster rate than earnings. The differential between these two rates of increase has fluctuated widely, being as high as somewhat more than 5 percent in some years and as low as a negative differential of about 1 percent in 1956 (with the next lowest differential being a positive one of about 1 percent in 1962). Over the entire 10-year period, the differential between the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 2.7 percent.

Your committee was advised by the Department of Health, Education, and Welfare that, in the future, earnings are estimated to increase at a rate of about 3 percent per year. It is much more difficult to predict what the corresponding increase in hospital costs will be. It would appear that, at the least, hospital costs would increase about 2 percent per year more than earnings for a few years and that, at the most, this differential rate would be 3 percent per year. It is recognized, of course, that these "minimum" and "maximum" assumptions result in a relatively wide spread in the cost estimates for hospital insurance proposals if the estimates are carried out for a number of years into the future.

(2) Assumptions underlying original cost estimates for the administration's bill, H.R. 3920 and S. 880, 88th Congress (the "King-Anderson" bill)

By way of background to the development of the cost estimates for the hospital insurance system that would be established by your committee's bill, there follows a discussion of cost estimates on the administration's proposals in the 88th Congress and in this Congress.

The actuarial cost estimates for H.R. 3920 and S. 880, 88th Congress, made at the time of its introduction in 1963 were presented in detail—as to assumptions, methodology, and results—in Actuarial Study No. 57 of the Social Security Administration.

In considering the hospitalization-benefit costs in conjunction with a level-earnings assumption for the future, it is sufficient for the purposes of long-range cost estimates merely to analyze possible future trends in hospitalization costs relative to covered earnings. Accordingly, any study of past experience of hospitalization costs should be made on this relative basis. The actual experience in recent years has indicated, in general, that hospitalization costs have risen more rapidly than the general earnings level, with the differential being in the neighborhood of 3 percent per year—2.7 percent in the last 10 years.

A major consideration in making cost estimates for hospitalization benefits, then, is how long and to what extent this tendency of hospital costs to rise more rapidly than the general earnings level will continue in the future, and whether or not it may in the long run be counterbalanced by a trend in the opposite direction. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly "catching up" with the general level of wages and obviously may be expected to "catch up" completely at some future date, rather than to increase indefinitely at a more rapid rate than wages generally) and the development of new medical techniques and procedures, with resultant increased expense.

In connection with this factor, there are possible counterbalancing factors. The higher costs involved for more refined and extensive treatments may be offset by the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also, it is possible that at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital services or for other reasons, so that, as in other fields of economic activity, the general wage level might increase more rapidly than hospitalization prices in the long run.

Perhaps the major consideration in making and in presenting these actuarial cost estimates for hospitalization benefits is that—unlike the situation in regard to cost estimates for the monthly cash benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base and the dollar amounts of any deductibles are concerned). The reason for this result is that in Actuarial Study No. 59 the fundamental actuarial assumption was made that hospitalization costs would rise at the same rate over the long run as the total earnings level, whereas the contribution income would rise less rapidly than the total earnings level unless the earnings base is kept up to date. Under these condi-

tions, it is necessary that the base be kept up to date with the changes in the general level of earnings, since contributions depend on the covered earnings level, and this level is dampened if the earnings base is not raised as earnings go up. Accordingly, it was necessary in the actuarial cost estimates for hospitalization benefits in Actuarial Study No. 59 to assume either that earnings levels will be unchanged in the future or that, if wages continue to rise (as they have done in the past), the system will be kept up to date insofar as the earnings base and the deductibles are concerned.

The basic assumption underlying the actuarial cost estimates in Actuarial Study No. 57 was that the relationship between earnings and hospital costs would, on the average, be the same into the future as in the 1961 experience. Alternatively and equivalently, these assumptions meant that earnings and hospital costs will rise, on the average, at the same rate in the future and that the earnings base will be adjusted proportionately with changes in the earnings level.

(*3*) *Alternative assumptions for hospitalization-benefits cost estimates*

One alternative basis for the assumptions that have just been discussed would assume the continuation into the long-range future of recent trends in the relationship between hospitalization costs and the general wage level, while at the same time assuming that there would be no change in the maximum earnings base under the system.

In the recent past, the general earnings level has increased at a rate of about 4 percent a year, while hospital costs have risen about 7 percent a year, so that there is a differential of about 3 percent. Assuming the continuation of these trends into the *indefinite future* and assuming, at the same time, no change in the maximum earnings base would have the following effects:

(1) Eventually hospitalization costs would exceed 100 percent of the earnings of all workers in the country—let alone, of taxable earnings.

(2) Virtually everyone entitled to cash benefits under the system would have the maximum benefit prescribed under the law, since they would have their benefits figured on the maximum creditable earnings. The earnings of the lowest paid part-time workers would eventually rise to the present maximum earnings base.

(3) The cash benefits of the system would be only a very small proportion of a person's previous earnings.

(4) As a percentage of taxable payroll, the cost of the cash-benefits portion of the system would be considerably lower than it is presently estimated to be—to the extent of about 1¼ percent of taxable payroll.

Such an assumption was not used in the cost estimates because it is considered to be completely unrealistic—and could be considered an "impossible" one. It is inconceivable that hospital prices would rise indefinitely at a rate faster than earnings because eventually individuals—even currently employed workers, let alone older persons—could not afford to go to a hospital under such cost circumstances.

As a numerical example, consider a full-time male worker now earning the "typical" amount of $20 per day, or $5,200 per year. The average daily cost for hospitalization (including not only room and

board, but also other charges) for persons of all ages is about $40, currently, or twice the average daily wage. If wages increase 4 percent per year, and if hospital costs increase 7 percent per year—indefinitely into the future—then the following situation will occur:

Item	At present	In 20 years	In 50 years
Average daily wage	$20	$43.82	$142.13
Average daily hospitalization cost	$40	$154.79	$1,178.28
Ratio of hospital cost to average daily wage (percent)	200	353	829
Proportion of wage covered by $5,600 base (percent)	100	54	16

Consideration of the foregoing figures indicates that, whereas the cost of a hospital day now averages about 2 days' wages, then in 50 years if the assumed trends take place, the cost of a hospital day will be over 8 days' wages. Quite obviously, it is an untenable assumption that there can be a sizable differential between the increase in hospitalization costs and the increase in earnings levels that will continue for a longer period into the future.

(4) Assumptions underlying original cost estimates for the administration's bill, H.R. 1 and S. 1, 89th Congress (the "King-Anderson" bill)

The Advisory Council on Social Security Financing, which was appointed in 1963 and completed its work by the end of 1964, considered the subject of hospitalization benefits and made significant recommendations in this field that were quite similar to the corresponding provisions contained in the administration's bill, H.R. 1 and S. 1, 89th Congress, introduced in January 1965. Further details on the recommendations of the Advisory Council and on the cost assumptions that it suggested may be found in its report "The Status of the Social Security Program and Recommendations for Its Improvement" (app. V, 25th Annual Report of the Board of Trustees, H. Doc. No. 100, 89th Cong.).

The Advisory Council stressed that the assumptions used in estimating hospital insurance costs should be conservative (i.e., where judgment issues arise, they should be resolved in a direction that would yield a higher cost estimate). The assumptions suggested by the Advisory Council were that the estimated 1965 hospitalization costs should be assumed to increase in the future in relation to total earnings rates by a net differential of 2.7 percent per year for the first 5 years after 1965, with this differential then being assumed to decrease to zero over the next 5 years; during the following 5 years, the differential is assumed to reverse, and after 1980 earnings are assumed to rise at an annual rate that is 0.5 percent greater than the increase in hospitalization costs.

The cost estimates made for H.R. 1 and S. 1 (as contained in Actuarial Study No. 59 of the Social Security Administration) were on the same basis as to hospitalization-cost assumptions as recommended by the Advisory Council. The long-range cost estimates were developed on the basis that the base figure for average daily hospitalization costs would be 1963 (since the cost estimates for both the cash benefits and the hospitalization benefits are founded on this basic assumption). This, in turn, meant that there was also the

coordinate assumption that the earnings base would, in the future, keep up to date with what $5,600 represented in 1963.

(5) Assumptions as to relative trends of hospitalization costs and earnings underlying cost estimate for committee bill—H.R. 6675

As indicated previously, your committee very strongly believes that the financing basis of the new hospital insurance program should be developed on a conservative basis. For the reasons brought out previously, the cost estimates should not be developed on a level-earnings basis, but rather they should assume dynamic conditions as to both earnings levels and hospitalization costs. Accordingly, it seems appropriate to make cost projections for only 25 years in the future and to develop the financing necessary for only this period (but with a resulting trust fund balance at the end of the period equal to about 1 year's disbursements). Although the trend of beneficiaries aged 65 and over relative to the working population will undoubtedly move in an upward direction after 25 years from now, it seems impossible to predict what the trend of medical costs and what hospital-utilization and medical-practice trends will be in the distant future.

Accordingly, for the purposes of the cost estimates in this report, the assumptions as to the relative trend of hospitalization costs as compared with the general earnings level have been modified somewhat as compared with the relatively conservative assumptions recommended by the Advisory Council. The same differential of hospital costs over earnings for the first 10 years is used, but thereafter the assumption is made that these two elements increase at the same rate (rather than having a negative one-half of 1 percent annual differential, as in the Advisory Council recommendations). In other words, the basis of the hospitalization-cost trends used in the cost estimates of this report are on a more conservative basis than recommended by the Advisory Council and, in fact, are more conservative than those used by the insurance business for its estimates for proposals of this type.

(6) Assumptions as to hospital utilization rates underlying cost estimates for committee bill—H.R. 6675

It should be pointed out that the hospital utilization assumptions for the cost estimates prepared by the Social Security Administration and also those in this report have always been founded on the hypothesis that current practices in this field will not change relatively more in the future than past experience has indicated. In other words, no account is taken of the possibility that there will be a drastic change in philosophy as to the best medical practices, so as, for example, to utilize in-hospital care to a much greater extent than is now the case.

The hospital utilization rates used for the cost estimates for the various past proposals (H.R. 3920 and S. 880, 88th Congress; the Advisory Council plan; and H.R. 1 and S. 1, 89th Congress) were the same in all instances. In view of the fact that testimony of the insurance business and the Blue Cross stated their belief that higher utilization would develop (actually, by as much as 40 percent higher in the early years of operation), your committee has adopted higher utilization rates than those used previously by the Social Security Administration. The increase in the early-year utilization rates is about 20 percent. Half of this can be attributed to changing the

previous assumption of low-cost utilization rates in the early years to the assumption of the intermediate-cost rates then; the latter were previously used only after the program would be in operation for a few years and the beneficiaries would have better knowledge of the benefits available. The other half of the increase in the utilization rates can be said to represent a basic adjustment upward for all future years, which can be viewed as a safety factor.

In other words, the current estimates can be considered to be high-cost ones, as compared with the intermediate-cost ones formerly used by the Social Security Administration. Another factor that may be used to justify the higher utilization rates used in these cost estimates is the somewhat greater amount of hospitalization which might result from the availability of the physicians' services benefits for in-hospital cases made available under the supplementary health insurance benefits program contained in your committee's bill.

(7) Assumptions as to hospital per diem rates underlying cost estimates for committee bill—H.R. 6675

The average daily cost of hospitalization that is used in these cost estimates is computed on the same basis as the corresponding figures in Actuarial Study No. 59 of the Social Security Administration. These per diem costs were in close agreement with what the Blue Cross testimony indicated, although some 13 percent below the estimates of the insurance business. The reason for the latter differential is that the insurance business did not make as large an allowance for a lower average daily cost for persons aged 65 and over and for hospital expenses that are not related to inpatients. The only significant change in the average daily hospitalization cost figures was a reduction by about 4 percent to allow for the exclusion from the hospital insurance system that would be established by your committee's bill of the in-hospital costs arising from the professional services of radiologists, anesthesiologists, pathologists, and physiatrists (the costs for such services would be covered under the supplementary health insurance benefits plan).

(d) Results of cost estimates

(1) Summary of cost estimates for H.R. 1 and S. 1, 89th Congress, under various cost assumptions

Table B summarizes the cost estimates that would be made for H.R. 1 and S. 1, 89th Congress (the King-Anderson bill), under various cost assumptions that have been used in the past, and also under those that are being used for your committee's bill. This analysis is made, with a single plan as the base point, so as to show the effect of the various assumptions. The variations shown arise from changes in a number of the cost factors—the relative trend of hospitalization costs as compared with earnings; the period over which the cost estimates are made, and whether static or dynamic assumptions are involved; and the hospital utilization rates.

In all the previous cost estimates, it was assumed that the maximum taxable earnings base would be kept up to date, by periodic changes, with changes in the general earnings level, and also that the same would be true of any deductibles. In regard to the latter element, many of the proposals had provisions calling for increases in the deductible amounts as hospital costs increase in the future so that the condition was thus satisfied; this is the case in connection with the hospital and outpatient diagnostic deductibles in your committee's bill.

With regard to the assumption that the earnings base would be kept up to date in the future, your committee believes that this is not a conservative assumption, since it seems to bind future Congresses into taking action in order to maintain the actuarial soundness of the hospital insurance system. It should be emphasized that the actuarial soundness of the cash benefits program under the old-age, survivors, and disability insurance system does not at all depend upon an assumption of the earnings base being adjusted upward when wages rise (but rather, on the contrary, the actuarial status of the system is improved under such circumstances). Accordingly, although your committee believes that, under the likely conditions of rising wages over the next 25 years, the earnings base will be adjusted upward beyond the two increases contained in your committee's bill (from the present $4,800 to $5,600 in 1966, and to $6,600 in 1971), the conservative assumption should be made for the purposes of the actuarial cost estimates that no further increases will occur after 1971.

TABLE B.—*Summary of cost estimates for hospital insurance benefits of H.R. 1 and S. 1, 89th Congress, under various cost assumptions*

Assumptions as to earnings base	Assumptions as to relative trends of hospitalization costs and earnings	Estimated level-cost [1]
COST ESTIMATES PREPARED ON LONG-RANGE LEVEL-EARNINGS ASSUMPTIONS		
(1) Keeps up to date with what $5,600 was in 1963.	Over the long range, hospitalization costs and earnings increase at same rate from 1961 on.	0.67% (basis of Actuarial Study No. 57, 1963).
(2) Keeps up to date with what $5,600 was in 1963.	Past experience projected to 1965; in next 5 years, hospitalization costs, rise more rapidly than earnings—by a total differential of 10%; thereafter, hospitalization costs and earnings rise at same rate.	0.81% (basis of cost estimates developed for 1964 legislation).
(3) Keeps up to date with what $5,600 was in 1963.	Past experience projected to 1965; hospitalization costs rise more rapidly than wages by 2.7% for 5 years; then this differential is reduced to zero in next 5 years and after 1975 wages rise more rapidly than hospitalization costs by ½% per year.	0.84% (basis of cost estimates for Advisory Council and in Actuarial Study No. 59, 1965).
(4) Keeps up to date with what $5,600 was in 1963.	Past experience projected to 1965; hospitalization costs rise more rapidly than wages by 2.7% for 5 years; then, this differential is reduced to zero in next 5 years; after 1975, hospitalization costs and wages increase at same rate.	0.87%.
(5) Keeps up to date with what $5,600 would be in 1966.	Same as in (4)	0.90%.
COST ESTIMATES PREPARED ON LONG-RANGE RISING-EARNINGS ASSUMPTIONS		
(6) Same as in (5)	Same as in (4)	0.96%.
(7) Remains at $5,600 through 1970; brought up to date by increase to $6,600 in 1971 and increased correspondingly every 5th year thereafter.	Same as in (4)	0.98%.
(8) Remains at $5,600 through 1970; increases to $6,600 in 1971 and then remains constant.	Same as in (4)	1.09%.[2]

[1] Except for items (1) and (2), which are on a perpetuity basis, the figures are for the level-cost over a 25-year period. expressed as a percentage of taxable payroll; includes margin so that trust fund balance at end of period equals the disbursements for that year.

[2] All the cost estimates for items (1) to (8) are based on the hospital utilization rates of Actuarial Study No. 59 of the Social Security Administration. The level-cost for item (8) would be increased to 1.21% under the hospital utilization rates of the estimates of this report.

(2) Level-costs of hospitalization and related benefits

As shown in footnote 2 of table B, the level-cost of the hospital benefits that would be provided under H.R. 1 and S. 1, 89th Congress, is 1.21 percent of taxable payroll, under the assumptions that the earnings base would be the same as in your committee's bill and would not change after 1971, and that both hospitalization costs and general earnings will continue to rise during the entire 25-year period considered in the cost estimates. The corresponding level-cost of the hospital and related benefits in your committee's bill is 1.23 percent of taxable payroll. The small difference arises from several factors. A higher cost arises for your committee's bill because the self-employed contribute on a lower rate basis (i.e., at the employee rate instead of 1½ times the employee rate), because there are more insured persons (due to the transitional insured status provisions for certain persons aged 72 and over), and because of the direct coverage of railroad workers (more thorough consideration of the effect of the financial interchange provisions in the previous proposals has now been given). On the other hand, there is a lower cost under your committee's bill because of the exclusion of all in-hospital physician services and of pre-hospital home health services, but this only partially offsets the factors mentioned in the previous sentence.

The level-equivalent of the contribution schedule in your committee's bill (as described previously) is also 1.23 percent of taxable payroll. Accordingly, these estimates indicate that the hospital insurance program is in exact actuarial balance under the assumptions made (and described previously).

The estimated level-cost of the hospital and related benefits of 1.23 percent consists predominantly of the cost of the hospital benefits. It does not seem feasible to attempt to subdivide the cost for the hospital benefits and the extended care facility benefits between these two categories. In the early years, virtually all of such costs will be for hospital benefits. Perhaps only about $25 to $50 million will be expended in 1967 for extended care facility benefits. In later years, it seems quite possible that greater use of post-hospital extended care services will be made, thus tending to reduce the use of hospitals. From a cost standpoint then, it seems desirable to consider hospital benefits and extended care facility benefits in combination, and it is estimated that the level-cost therefor is 1.19 percent of taxable payroll. The level-cost of outpatient hospital diagnostic benefits is estimated at 0.01 percent of taxable payroll, with the cost in the first full year of operations being about $10 million. Finally, the estimated level-cost of the post-hospital home health benefits is 0.03 percent of taxable payroll, a figure that allows for a considerable expansion of these services in the future (with the cost in the first full year of operations being estimated at less than $10 million).

As indicated previously, one of the most important basic assumptions in the cost estimates presented herein is that the earnings base is assumed to remain unchanged after it increases to $6,600 in 1971, even though for the remainder of the period considered (up to 1990) the general earnings level is assumed to rise at a rate of 3 percent annually. If the earnings base does rise in the future to keep up to date with the general earnings level, then the contribution rates required would be lower than those scheduled in your committee's

bill. In fact, if this were to occur, the steps in the contribution schedule beyond the combined employer-employee rate of 1.1 percent would not be needed. Furthermore, under the foregoing conditions, if the hospital utilization experience followed the intermediate-cost assumptions made previously in Actuarial Study No. 59 of the Social Security Administration (increased by 10 percent for the estimates presented in this report), and if all other conditions (such as the relationship of hospitalization costs and general earnings) developed as they are set forth in the assumptions, then it is possible that the combined employer-employee contribution rate would not have to increase beyond 1.0 percent.

(3) Number of persons protected on July 1, 1966

It is estimated that on July 1, 1966, the total population of the United States (including American Samoa, Guam, Puerto Rico, and the Virgin Islands) who are aged 65 and over will be 19.10 million (after allowance for underenumeration in the census counts and in population projections based thereon).

The total number of such persons who are estimated to be eligible for the hospital and related benefits on the basis of insured status under the old-age, survivors, and disability insurance system and the railroad retirement system is 16.95 million. Of the remaining 2.15 million, about 2.00 million are estimated to be eligible for the hospital and related benefits under the transitional provision on eligibility of presently uninsured individuals, as contained in your committee's bill. The remaining 150,000 persons are not eligible for hospital and related benefits because they are active or retired employees who are eligible (or had the opportunity to be eligible) for more comprehensive benefits under the Federal Employees Health Benefits Act of 1959, because they are alien residents who do not meet the residence requirements, or because they are subversives.

The cost for the 2.00 million persons who would be blanketed in for the hospital and related benefits is met from the General Treasury (with the financial transactions involved passing through the hospital insurance trust fund). The costs so involved, along with the financial transactions, are not included in the preceding cost analysis or in the following discussions of the progress of the hospital insurance trust fund. A later portion of this section, however, discusses these costs for the blanketed-in group.

(4) Future operations of hospital insurance trust fund

Table C shows the estimated operation of the hospital insurance trust fund under your committee's bill. According to this estimate, the balance in the trust fund would grow steadily in the future, increasing from about $560 million at the end of 1966 to $1.9 billion 5 years later. Over the long range, the trust fund would build up steadily, reaching $9.9 billion in 1990 (representing the benefit outgo for 1.1 years at the level of that time).

TABLE C.—*Estimated progress of hospital insurance trust fund*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
1966	$1,578	$982	[1] $50	$17	$562
1967	2,601	2,192	66	20	925
1968	2,790	2,391	72	34	1,286
1969	2,879	2,607	78	45	1,525
1970	2,983	2,840	85	50	1,633
1971	3,327	3,055	92	55	1,868
1972	3,488	3,280	98	60	2,038
1973	3,929	3,516	105	68	2,414
1974	4,120	3,760	113	77	2,738
1975	4,267	4,028	121	84	2,950
1980	6,123	5,276	158	140	5,018
1985	7,038	6,823	205	236	7,681
1990	9,030	8,754	263	306	9,948

[1] Including administrative expenses incurred in 1965.

NOTE.—The transactions relating to the noninsured persons, the costs for whom is borne out of the general funds of the Treasury, are not shown in the above figures.

(*e*) *Cost estimate for hospitalization benefits for noninsured persons paid from general funds*

Your committee's bill would provide hospitalization and related benefits not only for beneficiaries of the old-age, survivors, and disability insurance system and the railroad retirement system, but also for most persons aged 65 and over in 1966 (and for many of those attaining this age in the next few years) who are not insured under either of these two social insurance systems. Such benefit protection would be provided to any person aged 65 and over on July 1, 1966, who is not eligible as an old-age, survivors, and disability insurance or railroad retirement beneficiary and who (*a*) is not an employee of the Federal Government or a retired Federal employee eligible (or who had the opportunity to be eligible) for health benefits under the Federal Employees Health Benefits Act of 1959, (*b*) is not a member of a subversive organization and has not been convicted of subversive activities, and (*c*) is a citizen or has had at least 10 years of continuous residence.

Persons meeting such conditions who attain age 65 before 1968 also would qualify for the hospitalization benefits, while those attaining age 65 after 1967 must have some old-age, survivors, and disability insurance or railroad retirement coverage to qualify—namely, 3 quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1965 and before the year of attainment of age 65 (e.g., 6 quarters of coverage for attainment of age 65 in 1968, 9 quarters for 1969, etc.). This transitional provision "washes out" for men attaining age 65 in 1974 and for women attaining age 65 in 1972, since the fully-insured-status requirement for monthly benefits for such categories is then no greater than the special-insured status requirement.

The benefits for the "noninsured" group would be paid from the health insurance trust fund, but with simultaneous reimbursement therefor from the general fund of the Treasury on a current basis.

The estimated cost to the general fund of the Treasury for the hospitalization and related benefits for the noninsured group is as follows for the first 5 calendar years of operation (in millions):

Calendar year:	*Cost to General Treasury*
1966 (last 6 months)	$140
1967	275
1968	270
1969	260
1970	250

The cost to the general fund of the Treasury decreases slowly for the closed group involved. Offsetting, in large part, the decline in the number of eligibles blanketed in is the increasing hospital utilization per capita as the average age of the group rises and the increasing hospitalization costs in future years.

5. ACTUARIAL COST ESTIMATES FOR THE VOLUNTARY SUPPLEMENTARY HEALTH INSURANCE BENEFITS SYSTEM

(a) Summary of actuarial cost estimates

The supplementary health insurance benefits system that would be established by your committee's bill has an estimated cost for benefit payments incurred and for administrative expenses that would adequately be met during the first 2 years of operation (1966–67) by the individual premium rates prescribed plus the equal matching contributions from the general fund of the Treasury. Both contributions and benefit payments would begin in July 1966. In subsequent years, your committee's bill provides for appropriate adjustment of the premium rates so as to assure that the program will be adequately financed, along with the establishment of sufficient contingency reserves. Although provision is made for an advance appropriation from general revenues to provide a contingency reserve during the period July 1966 through June 1967, it is believed that this will not actually have to be drawn upon, but nonetheless it serves as a desirable safeguard to the financing basis of the program.

Just as in the case of the hospital insurance system, it is essential that the operating experience of a vast new program such as this should be subject to prompt, thorough actuarial review and study. Accordingly, your committee approves of the suggestion that has been made for a small random sample of the eligibles to be maintained on a current basis, so as to permit intensive study by the actuary without the delay that would be inherent in attempting to obtain operating experience data for the entire group of persons covered under the system

(b) Financing policy

(1) Self-supporting nature of system

Your committee has recommended the establishment of a supplementary health insurance benefits program that can be voluntarily elected, on an individual basis, by virtually all persons aged 65 and

over in the United States. This program is intended to be completely self-supporting from the contributions of covered individuals and from the equal-matching contributions from the general fund of the Treasury. Initially (for the period July 1966 through December 1967), the premium rate is established at $3 per month, so that the total income of the system per participant per month will be $6. Persons who do not elect to come into the system at as early a time as possible will generally have to pay a higher premium rate than $3. Under your committee's bill, the monthly premium rate can be adjusted for future years after 1967 so as to reflect the expected experience, including an allowance for a margin for contingencies. All financial operations for this program would be handled through a separate fund, the supplementary health insurance benefits trust fund.

Your committee's bill also provides for the establishment of an advance appropriation from the General Treasury that will serve as an initial contingency reserve in an amount equal to $18 (or 6 months' per capita contributions from the General Treasury) times the number of individuals who are estimated to be eligible for participation in July 1966. This amount, which is approximately $345 million, would be appropriated before July 1, 1966, but it would not actually be transferred to the supplementary health insurance benefits trust fund unless, and until, some of it would be needed. This contingency amount would be available only during the first year of operations (July 1966 through June 1967), and any amounts actually transferred to the trust fund would be subject to repayment of the funds of the Treasury (without interest).

(*2*) *Actuarial soundness of system*

The concept of actuarial soundness for the old-age, survivors, and disability insurance system and for the hospital insurance system is somewhat different than that for the supplementary health insurance benefits program. In essence, the last system is on a "current cost" financing basis, rather than on a "long-range cost" financing basis. The situations are essentially different because the financial support of the supplementary health insurance benefits system comes from a premium rate that is subject to change from time to time, in accordance with the experience actually developing and with the experience anticipated in the near future. The actuarial soundness of the supplementary health insurance benefits program, therefore, depends only upon the "short-term" premium rates being adequate to meet, on an accrual basis, the benefit payments and administrative expenses over the period for which they are established (including the accumulation and maintenance of a contingency fund).

(*c*) *Results of cost estimates*

(*1*) *Cost assumptions*

Only a relatively small amount of data is available in regard to the physician's services and other services that would be covered by the supplementary health insurance benefits system. The cost estimates used in determining the premium rate to be charged to individuals,

along with the matching Government contribution, have utilized data from the experience under the Federal Employees Health Benefits Act of 1959 for persons aged 65 and over, the experience under the Connecticut 65 program, and various information obtained by the National Health Survey conducted on a periodic basis by the Public Health Service of the Department of Health, Education, and Welfare.

The cost estimates have been made on a conservative basis—as seems essential in a newly established program of this type for persons aged 65 and over, most of whom have not previously had such insurance. It is believed that the $6 total per capita income of the system (from the premiums of the individuals and the matching Government contributions) will be fully adequate to meet the costs of administration and the benefit payments incurred, as well as to build up a relatively small contingency reserve. It is believed that there will be no need to draw upon the advance appropriation that is provided from general revenues.

Two cost estimates have been presented in regard to the possible per capita cost. Under the low-cost estimate, the benefits and administrative expenses will, on an accrual basis, represent about 75 percent of the contribution income, whereas under the high-cost estimate, the corresponding ratio will be almost 100 percent.

In an individual voluntary-election program such as this, it is impossible to predict accurately in advance what proportion of those eligible to participate in the program will actually do so. Accordingly, the cost estimates have been presented on two bases—an assumed 80 percent participation and an assumed 95 percent participation. Both of these estimates assume that virtually all State public assistance agencies will "buy in" for their old-age assistance recipients.

(2) Short-range operations of supplementary health insurance benefits trust fund

Table D presents estimates of the operation of the supplementary health insurance benefits trust fund for the first 2 years of operation, 1966–67. As indicated previously, four sets of estimates are given, under different assumptions as to low-cost and high-cost estimates and low and high participation. A significant balance in the trust fund develops in 1966, because of the lag involved in making benefit payments, since there are the factors of administrative processing and of the deductible that must be met first before any benefits are payable. In this respect, it will be noted that the income from premium payments by individuals will go into the trust fund beginning in the early part of July 1966, and the matching Government contributions will go into the trust fund simultaneously.

Under the low-cost estimates, the trust fund is estimated to have a balance of about $300 to $350 million at the end of 1966, and between $600 and $700 million at the end of 1967. On the other hand, under the high-cost estimates, the balance in the trust fund at the end of 1966 will be between $200 and $250 million, and will remain at substantially this level during 1967.

TABLE D.—*Estimated progress of supplementary health insurance benefits trust fund*

[In millions]

Calendar year	Contributions		Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
	Participants	Government				
	Low cost estimate, 80-percent participation					
1966 [1]	$275	$275	$195	$65	$5	$295
1967	560	560	765	75	15	590
	Low-cost estimate, 95-percent participation					
1966 [1]	$325	$325	$230	$80	$5	$345
1967	665	665	905	90	20	700
	High-cost estimate, 80-percent participation					
1966 [1]	$275	$275	$260	$85	$5	$210
1967	560	560	1,025	95	10	220
	High-cost estimate, 95-percent participation					
1966 [1]	$325	$325	$310	$100	$5	$245
1967	665	665	1,220	110	10	255

[1] Contributions would be collected only during the last 6 months of 1966, and benefit payments would likewise be payable only during that period. Administrative expenses shown include both those for the full year 1966 and such expenses as incurred in 1965.

NOTE.—Not included above is the advance appropriation from general revenues that is to provide a contingency reserve during fiscal year 1966–67 (to be used only if needed and to be repayable).

6. IMPROVEMENT AND EXTENSION OF KERR-MILLS PROGRAM

(*a*) *Background*

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of the needy aged, blind, disabled, and dependent children—the so-called vendor payments. This method of providing care has proved popular with the suppliers of medical care, the agencies administering the programs, and the recipients themselves.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who

have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and 227,000 aged were aided in December 1964. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

Your committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, your committee bill would establish, effective January 1, 1966, a new title in the Social Security Act—"Title XIX: Grants to the States for Medical Assistance Programs." After an interim period ending June 30, 1967, all vendor payments for medical care, including medical assistance for the aged, would be administered under the provisions of the new title. Until June 30, 1967, States might continue operating under the vendor payment provisions of title I (old-age assistance and medical assistance for the aged), title IV (aid to families with dependent children), title X (aid to the blind), title XIV (aid to the permanently and totally disabled), and title XVI (the combined adult program), or if they wish, they might move as early as January 1, 1966, to the new title. Programs of vendor payments for medical care will continue, as now, to be optional with the States.

(*b*) *State plan requirements*

(*1*) *Standard provisions*

The provisions in the proposed title XIX contain a number of requirements for State plans which are either identical to the existing provisions of law or are merely conforming changes. These are:

That a plan shall be in effect in all political subdivisions of the State.

That there shall be provided an opportunity for a fair hearing for any individual whose claim for assistance is denied or not acted upon with reasonable promptness.

That the State agency will make such reports as the Secretary may from time to time require.

That there shall be safeguards provided which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the administration of the plan.

That all individuals wishing to make application for assistance under the plan shall have an opportunity to do so and that such assistance shall be furnished with reasonable promptness.

That in determining whether an individual is blind there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

That medical assistance will be furnished to individuals who are residents of the State but who are absent therefrom.

(*2*) *Additions to standard provisions*

In addition to the requirements for State plans mentioned above, your committee bill contains several other plan requirements which are either new or changed over provisions currently in the law.

The bill provides that there shall be financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan and that effective July 1, 1970, the financial participation by the State shall equal all the non-Federal share. This provision was included to make certain that the lack of availability of local funds for financing of any part of the program not affect the amount, scope, or duration of benefits or the level of administration set by the State. Prior to the 1970 date, your committee will be willing to consider other legislative alternatives to the provisions making the entire non-Federal share a responsibility of the State so long as these alternatives, in maintaining the concept of local participation, assure a consistent statewide program at a reasonable level of adequacy.

The bill contains a provision found in the other public assistance titles of the Social Security Act that the State plan must include such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, with the addition of the requirement that such methods must include provisions for utilization of professional medical personnel in the administration of the plan. It is important that State utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff.

Your committee bill provides that the State or local agency administering the State plan under title XIX shall be the same agency which is currently administering either title I (old-age assistance) or that part of title XVI (assistance for the aged, blind, and the disabled, and medical assistance for the aged) relating to the aged. Where the program relating to the aged is State-supervised, the same State agency shall supervise the administration of title XIX. This provision was included because of the need to have the same agency which is most familiar with the administration of assistance (including medical care) to various groups of needy or nearly needy people also administer the medical assistance program. This is an agency with long experience and skill in determination of eligibility. Responsibility can be arranged by a welfare agency for actual provision of medical care by or through a health agency under suitable contractual relationships as some States have done under the MAA program.

Moreover, your committee recognizes that there are other State agencies with responsibilities for the provision of medical care or for various types of rehabilitative services in the States. In order to make certain that there is no duplication of effort and that maximum utilization will be made of the resources available from such other agencies, your committee bill provides that the State's plan must include provisions for entering into cooperative arrangements with State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the States.

Your committee bill also provides that if, on January 1, 1965, and on the date a State submits its title XIX plan, the State agency administering or supervising the administration of the State plan for the blind under title X or title XVI of the Social Security Act is different from the State agency administering or supervising the administration of the plan relating to the aged under title I or title XVI, such blind agency may be designated to administer or supervise the administration of the portion of the title XIX plan which relates to blind individ-

uals. In such case, the portion of the title XIX plan administered or supervised by each agency shall be regarded as a separate plan.

Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is expected that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

Under provisions of your committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance or that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided. Your committee expects that under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation and that they will develop such procedures as will assure the most effective working relationships with medical facilities, practitioners, and suppliers of care and service in order to encourage their full cooperation and participation in the provision of services under the State plan.

(*c*) *Eligibility fo medical assistance*

Under your committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI. These people are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people. Thus, under the provisions of the bill, these people will have the first call upon the resources of the States to provide medical care. It is only if this group is provided for that States may include medical assistance to the less needy than those who would be eligible for aid under the various other categories of public assistance.

Under your committee bill, medical assistance made available to persons receiving assistance under title I, IV, X, XIV, or XVI must not be less in amount, duration, or scope than that provided for persons receiving aid under any other of those titles. In other words, the amount, duration, and scope of medical assistance made available must be the same for all such persons. This will assure comparable treatment for all of the needy aided under the federally aided categories of assistance and will eliminate some of the unevenness which has been apparent in the treatment of the medical needs of various groups of the needy.

The bill provides furthermore that as States extend their programs to include assistance for persons who come within the various cate-

gories of assistance except that their income and resources are sufficient to meet their needs for maintenance, the medical assistance given such individuals shall not be greater in amount, duration, or scope than that made available for persons who are recipients of money payments. This was included in order to make sure that the most needy in a State receive no less comprehensive care than those who are not as needy.

Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs. Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children who, except for their income and resources, would be eligible for AFDC. The scope, amount, and duration of medical assistance available to each of these groups must be equal.

(*d*) *Determination of need for medical assistance*

Your committee bill would make more specific a provision now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards consistent with the objectives of the titles. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled; and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them.

Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary) are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him. Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available or overevaluate income and resources which are available. Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual. The provisions also are designed to assure that whatever is applicable under titles I, IV, X, XIV, and XVI for the disregarding of income or for setting aside of income shall also be applicable in evaluating the income of the individual who is applying for medical assistance under title XIX. Titles I and X now provide for the disregarding of certain income and title IV provides

that income may be set aside for the future needs of the children. Other pertinent provisions for the disregard of income are found in the Economic Opportunity Act and the Food Stamp Act of 1964.

Your committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. Your committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

The bill also contains a provision designed to correct one of the weaknesses identified in the medical assistance for the aged program. Under the current provisions of Federal law, some States have enacted programs which contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all of the aid provided under the State plan. Individuals, however, whose income exceeds the limitation adopted by the State are found ineligible for the medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of the medical care needed. In order that all States shall be flexible in the consideration of an individual's income, your committee bill requires that the States standards for determining eligibility for and extent of medical assistance shall take into account, except to the extent prescribed by the Secretary, the cost—whether in the form of insurance premiums or otherwise—incurred for medical care or any other type of remedial care recognized under State law. Thus, before an individual is found ineligible for all or part of the cost of his medical needs, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires.

The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income or resources which would bring the individual below the test of eligibility under the State plan. If the test of eligibility should be $2,000 a year, an individual with income in excess of that amount shall not be required to use his income to the extent he has remaining less than $2,000. This action would reduce the individual below the level determined by the State as necessary for his maintenance.

The bill contains several interrelated provisions which prohibit or limit the imposition of any deduction, cost sharing, or similiar charge,

nor of any enrollment fee, premium, or similar charge, under the plan.

No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect or require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan.

For any other items of medical assistance furnished under the plan, a charge of any kind may be imposed only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services. The Secretary is given authority to issue standards under this provision, which it is expected will protect the income and resources an individual has which are necessary for his nonmedical needs.

The hospital insurance benefit program included under other provisions of the bill provides for a deductible which must be paid in connection with the individual's claim for hospitalization benefits. Your committee is concerned that hospitalization be readily available to needy persons and that the necessity of their paying deductibles shall not be a hardship on them or a factor which may prevent their receiving the hospitalization they need. For this reason, your committee's bill provides that the States make provisions, for individuals 65 years or older, of the cost of any deductible imposed with respect to individuals under the program established by the hospital insurance provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income or income and resources and in conformity with standards issued by the Secretary. The Secretary is authorized to issue standards—under this provision which, it is expected, will protect the income and resources of the individual needed for his maintenance—to guide the States. Such standards shall protect the income and resources of the individual needed for his maintenance and provide assurance that the responsibility placed on individuals to share in the cost shall not be an undue burden on them.

Titles I and XVI authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments except pursuant to a court judgment concerning incorrect payments, and prohibits adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his surviving spouse. This provision, under your com-

mittee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled.

(e) *Scope and definition of medical services*

"Medical assistance" is defined under the bill to mean payment of all or part of the care and services for individuals who would if needy, be dependent under title IV, except for section 406(a)(2), and are under the age of 21, or who are relatives specified in section 406(b)(1) with whom the child is living, or who are 65 years of age and older, blind, or permanently and totally disabled, but whose income and resources are insufficient to meet all their medical care costs. The bill, as do current provisions of law, permits Federal sharing in the cost of medical care provided up to 3 months before the month in which the individual makes application for assistance. Thus, the scope of the program includes not only the aged, blind, disabled, and dependent children as defined in State plans, but also children under the age of 21 (and their caretaker relatives) who come within the scope of title IV, except for need and age, even though they may not be defined as eligible under a particular State plan.

Your committee bill contains a list of services, the first five of which the States are required to include in their plans, if they elect to implement title XIX, and the remainder of which are optional with the States. The required services are:

Inpatient hospital services.
Outpatient hospital services.
Other laboratory and X-ray services.
Skilled nursing home services.
Physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home or elsewhere.

In the opinion of your committee, these are the most essential items of service which should be included as a minimum if the medical assistance program is to be of significant help to the individual. These minimum items of service are to become effective July 1, 1967; until then, the State plan must include—as now provided in titles I and XVI—for some institutional and some noninstitutional services.

Other items of medical service which the States may, if they wish include in their plans are:

Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
Home health care services.
Clinic service.
Private duty nursing service.
Dental service.
Physical therapy and related services.
Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.
Other diagnostic, screening, preventive, and rehabilitative services.
Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

The States must pay the reasonable cost of inpatient hospital services for the number of days of care provided under the plan.

Among the items of medical services which the States may include is medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. Under this provision, a State may if it wishes, include medical and remedial services provided by osteopaths, chiropractors, optometrists and podiatrists, and Christian Science practitioners, if such practitioners and services are licensed by the State.

If a State chooses to provide eyeglasses as a service under the plan, your committee believes that the individual recipient should be free to select either a physician skilled in diseases of the eye or an optometristto provide these glasses. Many small communities do not have qualified ophthalmologists but do have optometrists who are competent to provide, fit, or change eyeglasses.

In addition to the items specifically listed, the Secretary is authorized to define any other medical care or any other type of remedial care recognized under State law which he believes might be provided by the States and in which the Federal Government will participate financially.

The State plan may not include any individual who is an inmate of a public institution, except as a patient in a medical institution; nor may it include any individual under the age of 65 who is a patient in an institution for tuberculosis or mental diseases.

Under title XIX, it will be possible for States to give medical assistance to persons 65 years of age and older who are in mental and tuberculosis institutions and to otherwise eligible persons of any age with a diagnosis of psychosis or tuberculosis and who are receiving care in other medical institutions. Under the bill, if the plan includes medical assistance for patients in institutions for mental diseases or tuberculosis, various requirements are specified for inclusion in the State plan with respect to these individuals and various other fiscal and other provisions are included. These are identical with those included in title II, part 3 of the bill and are explained elsewhere in this report.

Medical assistance provided under the bill may include payment for care and services provided at any time within the month in which an individual becomes eligible or ineligible for assistance, e.g., by attaining a specified age. This avoids the administrative inconvenience of having to segregate bills by the day of the month on which care or services were provided and is consistent with the monthly pattern of benefits under the other public assistance titles.

(f) Other conditions for plan approval

Title XIX requires that the Secretary approve any plan which fulfills the plan requirements specified and described above and which does not contain certain other conditions. Under these provisions, a State plan may not include an age requirement of more than 65 years. Effective July 1, 1967, States may not, under the provisions of your committee bill, exclude any individual who has not attained the age of 21 and is, or would, except for the provisions of section 406(a)(2) be a dependent child under title IV. Thus, States will include within the scope of their plan all children

under the age of 21—whether or not they are attending school or taking a program of vocational training—who would otherwise be within the scope of eligibility of a dependent child as defined under title IV of the Social Security Act. This provision was included in order to provide assurance that children under the age of 21 will have their medical needs met if they are either a member of a family receiving a money payment under title IV of the Social Security Act or a member of a family which has the need and other characteristics described under title IV.

The Secretary would be prohibited from approving any plan which imposed a residence or citizenship requirement that goes beyond those now in title I and title XVI as they relate to the medical assistance for the aged program. In addition, the Secretary is directed not to approve any State plan for medical assistance if he finds that the approval and operation of the plan will result in a reduction in the level of aid or assistance provided for eligible individuals under title I, IV, X, XIV, or XVI. An exception is provided allowing States to reduce such aid to the extent that assistance now provided under titles I, IV, IX, XIV, and XVI is to be provided under title XIX. The reason your committee recommends the inclusion of this provision is to make certain that States do not divert funds from the provision of basic maintenance to the provision of medical care. If the Secretary should find that his approval of a title XIX plan would result in a reduction of aid or assistance for persons receiving basic maintenance under the public assistance titles of the Social Security Act (except as specified above) he may not approve such a plan under title XIX. Your committee recognizes the need and urgency for States to maintain, if not improve, the level of basic maintenance provided for needy people under the public assistance programs. The provision is intended to prevent any unwarranted diversion of funds from basic maintenance to medical care.

(*g*) *Financing of medical assistance*

Your committee bill provides for payments under title XIX, beginning with the quarter commencing January 1, 1966. States with approved plans would receive an amount equal to the Federal medical assistance percentage of the total amount expended during a quarter as medical assistance under the State plan. This percentage is described below. The amount expended as medical assistance for purposes of Federal matching include expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under one of the Federal-State public assistance programs. This may include payment of premiums for those individuals covered under agreements between the State and the Secretary, and also for other money payment recipients who are eligible under part B of title XVIII. In addition, expenditures for other insurance premiums for medical or any other type of remedial care or the cost thereof are matchable as medical assistance. (The definitions of assistance in the public assistance titles of the Social Security Act would also be amended to include similar provisions.)

In addition, the States are to receive 75 percent of so much of the sums expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan as are attributable to the compensation of skilled professional medical person-

nel and staff directly supporting such personnel of the State agency or the local agency administering the plan in the political subdivision. This provision was included in order to provide adequate Federal financial support for the staffing of the State and local public welfare departments by such skilled professional medical personnel and staff directly supporting such personnel as may be necessary. Such staff will include physicians, medical administrators, medical social work personnel, and other specialized personnel necessary to assure an adequate number of persons to do a quality job as well as the clerical staff, directly associated with the professional staff, and the necessary travel and other closely related expenditures. It is very likely that some people in need of medical assistance will need related social services in order to receive the full benefits of the program. Under the 1962 public welfare amendments, States may receive 75 percent Federal sharing in the cost of services provided to persons receiving aid under titles I, IV, X, XIV, and XVI to former recipients of assistance under these titles and persons likely to become recipients of aid under these titles. Thus adequate provisions are already available to help the States finance the provision of social services to those receiving medical assistance or the cost of training staff to provide such services and no such provision is included in the new title.

In addition, the States are to receive one-half of all other expenditures found by the Secretary to be necessary for the proper and efficient administration of the State plan.

The Federal medical assistance percentage is determined in accordance with a formula described in the bill. It provides that a State whose per capita income is equal to the national average per capita income shall receive 55 percent Federal matching. States whose per capita income is below the national average shall receive correspondingly higher proportions of Federal funds up to a maximum of 83 percent. States whose per capita income is above the national average shall receive correspondingly lower percentages but not less than 50 percent. The medical assistance percentages for Puerto Rico, the Virgin Islands, and Guam shall be 55 percent. The method of determining the Federal medical assistance percentage and the frequency of its determination and promulgation are (after the initial promulgation for the period January 1, 1966, to June 30, 1967) already specified in the law.

There is a special provision for adjustment of the Federal medical assistance percentage for any State which might not otherwise receive full advantage from the title XIX formula. It is provided that during the period from January 1, 1966, through June 30, 1969, the Federal medical assistance percentage under title XIX for any State shall not be less than 105 percent of the Federal share of medical expenditures by the State during fiscal year 1965. The computation is made by determining the amount of Federal payments made to each State for fiscal year 1965 under all of the public assistance titles, which would not have been payable except for the making of vendor medical payments. This amount of Federal payments is compared with the total amount of vendor medical expenditures under the public assistance plans (whether below or above the matching ceilings under the Federal statutory formulas) to give the Federal share of medical expenditures by the State during fiscal year 1965. The raising of the

45-399 O—65——6

Federal medical assistance percentage to 105 percent of the Federal share of medical expenditures for 1965 will obviate certain inequities in the various formulas and will enable a few States which might not otherwise do so to receive some additional Federal funds as an incentive for an improved program.

Provisions relating to the availability of Federal sharing in the cost of medical assistance for persons 65 years of age or older who are patients in mental or tuberculosis hospitals specify that the States will receive additional Federal funds only to the extent that a showing is made to the satisfaction of the Secretary that the additional funds being received are being used to extend and improve the mental health program of the States. Comparable provisions appear in title II, part 3 of the bill, and are explained more fully in that part of this report relating to title II.

The provisions of title IV, section 405 of the bill, described elsewhere in this report are designed to assure that the additional Federal funds which are to accrue to the States under the operation of the formula described above, shall be used directly in the public assistance program and may not be withdrawn from the program by the States.

The bill sets forth provisions comparable to those which are in other of the public assistance titles of the Social Security Act describing the procedure by which the State submits its estimates of the funds it will need and receives payments under its approved plan, and the procedures to be followed in the event it should become necessary to question the continued receipt of Federal funds under the new title. There is also a new provision limiting payments made under the new title to States making a satisfactory showing of efforts toward broadening the scope of care and services made available under the plan. This showing must be such that the Secretary is reasonably convinced the program of medical assistance will have such liberalized eligibility requirements and comprehensive care and services, including needed social services to achieve independence or self-care that by July 1, 1975, assistance and services needed will be available to substantially all individuals who meet the State's eligibility standards with respect to income and resources. This provision was included in order to encourage the continued development in the States of a broadened and more liberalized medical assistance program so that all persons who meet the State's test of need, whose own resources, and the resources available to them under other programs for medical care, including those established for Federal matching under this bill, are insufficient, will receive the medical care which they need by 1975.

(h) Miscellaneous provisions

Title XIX would under the provisions of your committee bill become effective January 1, 1966. No payments may be made to a State under title I, IV, X, XIV, or XVI with respect to aid or assistance in the form of medical or other types of remedial care for any period for which such State receives payment under title XIX or for any period after June 30, 1967. Thus, under the provisions of your committee bill, a State is permitted to implement title XIX at any time it wishes commencing January 1, 1966, but must do so by July 1, 1967, if it wishes to receive Federal participation in vendor payments for medical care. When a title XIX plan has gone into effect pursuant to the bill, all vendor medical payments made on or after the effective date

(and administrative costs on or after the effective date, which are related to vendor medical payments) will be accounted for under title XIX, and not under the other titles.

The bill also makes technical and conforming amendments.

(*i*) *Cost of medical assistance*

As the accompanying table shows, if all States took full advantage of provisions of the proposed title XIX, the additional Federal participation would amount to $238 million. However, because all States cannot be expected to act immediately to establish programs under the new title and because of provisions in the bill which permit States to receive the additional funds only to the extent that they increase their total expenditures, the Department of Health, Education, and Welfare estimates that additional Federal costs in the first year of operation will not exceed $200 million. Since the new title would be effective only for the last 6 months of the fiscal year ending June 30, 1966, expenditures in that fiscal year are not expected to exceed $100 million.

Public assistance: Increased Federal funds available for medical payments under title XIX [1]

[In thousands of dollars]

State	Increase available under title XIX [1]	State	Increase available under title XIX [1]
Total	$238,005	Missouri	350
		Montana	27
Alabama	1,045	Nebraska	1,511
Alaska	5	Nevada	263
Arizona	19	New Hampshire	1,931
Arkansas	3,905	New Jersey	5,559
California	20,411	New Mexico	1,634
Colorado	2,689	New York	46,580
Connecticut	3,922	North Carolina	2,890
Delaware	8	North Dakota	3,809
District of Columbia	344	Ohio	2,871
Florida	684	Oklahoma	14,752
Georgia	363	Oregon	1,291
Hawaii	898	Pennsylvania	3,098
Idaho	477	Rhode Island	2,437
Illinois	18,395	South Carolina	2,133
Indiana	2,136	South Dakota	148
Iowa	5,315	Tennessee	324
Kansas	5,808	Texas	1,237
Kentucky	262	Utah	3,028
Louisiana	3,950	Vermont	330
Maine	781	Virginia	159
Maryland	141	Washington	2,290
Massachusetts	16,614	West Virginia	2,260
Michigan	3,715	Wisconsin	17,031
Minnesota	27,578	Wyoming	280
Mississippi	317		

[1] Based on expenditures for vendor medical payments from State and local funds for all programs combined in January 1964. If State and local expenditures were reduced, the Federal expenditure would be correspondingly lower, while increases in State and local expenditures would also result in increases in the Federal cost.

B. Child Health Amendments

1. SUMMARY OF COMMITTEE ACTION

Your committee believes that the proposals embodied in part 1, title II of its bill will help to improve the health care of many low-income preschool and school age children and youth.

Your committee's bill would—

(1) Increasing the amounts authorized for maternal and child health services and crippled children's services under title V of the Social Security Act in order to assist the States to move toward the goal of extending such services with a view to making them reasonably available to children in all parts of the State by July 1, 1975;

(2) Authorizing grants for the training of personnel to serve crippled children, particularly mentally retarded children and children with multiple handicaps, and;

(3) Authorizing a new 5-year program of special project grants to provide comprehensive health care and services for children of school age and for preschool children.

(*a*) *Maternal and child health services*

The amount of Federal funds going into maternal and child health services in the fiscal year 1964 was approximately $28 million. State and local funds were more than three times as much, about $92 million.

States use Federal funds, together with State and local funds, to pay the costs of conducting prenatal clinics where mothers are examined by physicians and get medical advice; for visits by public health nurses to homes before and after babies are born to help mothers care for their babies; for well-child clinics where mothers can bring their babies and young children for examination and immunizations, where they can get competent advice on how to prevent illnesses and where their many questions about the care of babies can be answered. Such measures have been instrumental in the reduction of maternal and infant mortality, especially in rural areas. Funds are used to make available doctors, dentists, and nurses to the schools for health examinations of schoolchildren. They are also used for immunizations. These funds support diagnostic, treatment and counseling services for mentally retarded children in 47 States. Practically all States use some of the funds for improving the quality of services to mothers and children by providing special training opportunities to physicians, nurses, nutritionists, medical social workers, and other professional personnel. In addition, States carry out demonstration programs of various kinds.

Your committee believes that increases in the child population and the cost of medical care, wide variations among the States in maternal and infant mortality, and the uneven distribution of basic health services indicate the need for additional Federal support in order to help States make their maternal and child health services available to children in all parts of the State by July 1, 1975.

Existing ceilings on authorizations for appropriations for maternal and child health services are:

$40 million each for the fiscal years ending June 30, 1966, and 1967;

$45 million each for the fiscal years ending June 30, 1968, and 1969; and

$50 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

Your committee's bill would authorize an increase in these ceilings on appropriations to:

$45 million for the fiscal year ending June 30, 1966;

$50 million for the fiscal year ending June 30, 1967;

$55 million each for the fiscal years ending June 30, 1968, and 1969; and

$60 million for the fiscal year ending June 30, 1970, and for succeeding fiscal years.

Such increases are authorized in order to help extend maternal and child health services to additional parts of the States, thus providing preventive health services for more mothers and children and contributing to further reduction of infant mortality through greater availability of services.

(*b*) *Crippled children's services*

About $29 million of Federal funds was expended for services for crippled children in fiscal year 1964. Expenditures from State and local funds were more than twice as much—nearly $60 million.

The program now includes children for whom medical or surgical care formerly was not available or feasible. Under the committee's bill, all State crippled children's agencies could make their services increasingly available to children with all kinds of handicaps such as cystic fibrosis, congenital heart disease, neurological disorders, epilepsy, hemophilia, and other problems. Some States have programs for the diagnosis, treatment, and aftercare of children with multiple handicaps, most of whom have varying degrees of mental retardation.

In 1963 about 400,000 children under 21 years of age received physicians' services under the crippled children's programs. Approximately 293,000 children attended diagnostic clinics and close to 70,000 children received hospitalization. About 35 percent of expenditures in the crippled children's program are for hospital care.

One-half of the children diagnosed in 1963 were children with nonorthopedic defects. Deformities of a congenital nature were the largest single group of primary conditions among children served, nearly 30 percent of all children served. Roughly 20 percent of these congenital conditions consisted of malformations of the heart and circulatory system.

However, differences in rate of service among States is considerable, the highest being 165 per 10,000, the lowest 15. This unevenness is indicative of the need for considerable growth of these programs in many States. Many crippled children or children with potentially crippling conditions do not receive needed care because their conditions may not be included in the State's program. For example, a number of States do not include children with epilepsy; others do not include children with strabismus, neglect of which often results in loss of vision in the affected eye; some States do not include children with hearing impairments. The major reason for these deficiencies in State programs is inadequate funds.

Existing authorizations for crippled children's services are:

$40 million each for the fiscal years ending June 30, 1966, and 1967;

$45 million each for the fiscal years ending June 30, 1968, and 1969; and

$50 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

Your committee's bill would authorize an increase in the ceiling on appropriations to:

$45 million for the fiscal year ending June 30, 1966;

$50 million for the fiscal year ending June 30, 1967;

$55 million each for the fiscal years ending June 30, 1968, and 1969; and

$60 million for the fiscal year ending June 30, 1970, and for succeeding fiscal years.

Such increases would assist the States to move toward the goal of extending crippled children's services with a view to making such services available to children in all parts of the State by July 1, 1975.

Extension of services for crippled children to areas of a State not now served will increase the number of children helped by the program, and make services more accessible in all parts of a State. The increased funds will also help States to extend their programs and further broaden their definitions of "crippling."

(*c*) *Training of professional personnel for the care of crippled children*

Your committee's bill would authorize a program of grants to institutions of higher learning for training (and related costs) of professional personnel such as physicians, psychologists, nurses, dentists, and social workers for work with crippled children and particularly mentally retarded children and those with multiple handicaps. Authorizations would be $5 million for the fiscal year ending June 30, 1967, $10 million for the fiscal year ending June 30, 1968, and $17.5 million for each fiscal year thereafter.

Of the 4.1 million children born each year about 3 percent—at birth or later—will be classified as mentally retarded. The 27,000 children in 1963 who were served by the 92 clinics in the country supported with maternal and child health and crippled children's funds represent only a small fraction of the children who need this kind of help. A large number of these children also have physical handicaps. Despite the growth in the number of clinics serving mentally retarded children, and the increase in the number of children served, waiting lists remain long. Lack of sufficient numbers of trained personnel to staff clinics is a major reason why applications for services for mentally retarded children exceed existing resources.

The growth of programs for children with various handicapping conditions including those who are mentally retarded and the construction of new university centers for clinical services and training are increasing the demands for adequate trained professional personnel. These centers will offer a complete range of services for the mentally retarded and will demonstrate programs of specialized services for the diagnosis, treatment, education, training, and care of mentally retarded children, including retarded children with physical handicaps. They will be resources for the clinical training of physicians and other specialized personnel needed for research, diagnosis, training, or care.

The program would help to reduce the severe shortage of professional personnel to serve mentally retarded children and children with multiple handicaps. The training of health personnel authorized is

not intended to, and in your committee's judgment will not, in any way duplicate other programs of training (such as those for teachers) of personnel to work with the mentally retarded.

(*d*) *Payment for inpatient hospital services*

The bill also provides for payment of the reasonable cost of inpatient hospital services provided under the State plans for maternal and child health services and crippled children's services. Reasonable costs are to be determined in accordance with standards approved by the Secretary.

(*e*) *Special project grants for low-income school and preschool children.*

The bill would authorize a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families. Projects would provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare for children in low-income families.

Your committee has evidence that many of the health needs of preschool children and children of school age, particularly children from low-income families, are not being met because of the increase in the child population. This is resulting in great crowding of clinics available to low-income families and inadequate preventive health services and medical care for their children.

The maternal mortality rate in 1961-62 in low-per-capita income States was 57 percent higher than in high-per-capita income States, 50 maternal deaths per 100,000 live births as compared with 31.9.

The infant mortality rate for low-income States in 1962, 29.6 per 1,000 live births, was 17 percent above that prevailing in high-income States.

Hospitalization rates for children coming from families whose income was under $2,000 were at the rate of 42.4 per 1,000 whereas children from families with incomes of $7,000 and over were hospitalized at the rate of 67.7 per 1,000.

The average length of hospital stay for all children under 15 was 6 days. For children whose family income was under $2,000 the average hospital stay was 9.3 days contrasted with 4.8 days for children coming from families with an income of $7,000 and over.

School aged children 5 to 17 numbered 44 million in 1960 and may reach 54 million by 1970, an increase of about 24 percent. The 4,250,000 children born in 1960 will be enrolled in school in 1966. Much can be done to help preschool children to get ready for school by correcting and preventing health handicaps.

Your committee is convinced that health supervision in the preschool years is important because many childhood disabling illnesses both physical and emotional have their origin in infancy or the preschool years. Effective health supervision for children during the years before entering school would help considerably to get them ready for school and reduce the extent of the need for school health services for

children in the first year of school. Such care should also be extended through adolescence.

In school health programs, the availability of community resources to which children can be referred for diagnosis and treatment is the critical factor in the essential followup services. Without such resources, school health services have little meaning for low-income families. Communities are finding that they do not have adequate resources to which children can be referred for diagnosis and treatment when they are found to be in need of treatment through school health programs and their resources for the examination, diagnosis, and treatment of preschool children to help them prepare to enter school are also too few and too crowded.

Large numbers of our children enter school and spend their schooldays with conditions which interfere with their growth, development, and education:

About 10,200,000 schoolchildren are in need of eye care;

About 1,500,000 children have hearing impairments—about 7 percent already have hearing loss when they enter school;

One in five children under age 17 has a chronic ailment;

Four million children are emotionally disturbed;

Half the children under 15 years in the United States have never been to a dentist and the proportion is much greater in families with incomes under $2,000;

Children in families with incomes of less than $2,000 visit the doctor only half as frequently as those in families with incomes of more than $7,000;

Your committee's proposal will make possible programs organized to make maximum use of available community medical services and to bring about a better distribution of the low-income patient group among public and voluntary community clinics and hospitals.

To be eligible for a grant a project must provide for—

(1) Coordination with and utilization of other State and local health, welfare, and education programs for such children;

(2) Payment of reasonable cost of in-patient hospital services;

(3) Treatment, correction of defects or after care to be available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control; and

(4) Inclusion of such screening, diagnosis, preventive services, treatment, correction of defects, and after care, medical or dental, as required by the Secretary.

Authorizations for appropriations would be:

$15 million for the fiscal year ending June 30, 1966;

$35 million for the fiscal year ending June 30, 1967;

$40 million for the fiscal year ending June 30, 1968;

$45 million for the fiscal year ending June 30, 1969, and $50 million for the fiscal year ending June 30, 1970.

A full report with evaluation and recommendations is to be submitted to the President for transmission to the Congress before July 1, 1969.

The grants would be available to the State health agency or with its consent to the health agency of any political subdivision of the State, to the State agency administering or supervising the crippled children's program, to schools of medicine (with appropriate participation by schools of dentistry) and to teaching hospitals affiliated with schools of medicine.

The grants would pay not to exceed 75 percent of the cost of projects. Your committee recognizes, however, that non-Federal funds may have to be derived from a variety of sources, particularly at the beginning of the program. These might include existing funds and activities of the grantee agency; funds, equipment, time of personnel, or space made available by other agencies; or similar items or gifts from other sources.

Your committee is aware that other committees of the Congress have before them legislative proposals dealing with school and preschool children. Your committee has studied these proposals carefully and is thoroughly satisfied that there is no duplication of the services provided in the special project health grants for school and preschool children incorporated in the proposed new section 532 of title V of the Social Security Act and no duplication is intended. Furthermore, the Appropriations Committee will have an opportunity to look at these programs at the same time and evaluate their interrelationships.

This program would enable State or local health agencies, crippled children's agencies, and medical schools and teaching hospitals to provide comprehensive health care including dental care to children in need of such care in areas where low-income families are concentrated and to improve the amount and quality of care available to children of low-income families by the organization of the necessary services to provide care. It would reduce the numbers of children of preschool and school age who are hampered by remediable handicaps and provide necessary medical and dental care for children of low-income families who would otherwise not receive care.

2. COSTS OF IMPROVEMENTS IN MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S PROGRAMS

The accompanying tables indicate by State the allotments that would be made under the maternal and child health and crippled children's programs under the existing authorization of $40 million for each of these programs for the fiscal year ending June 30, 1966, and the State allotments which would be made under the proposed authorization of $45 million. The differences by State shown in the tables reflect the amount of additional funds that States would receive under the provisions of the bill in fiscal year ending June 30, 1966. Differences for subsequent years would be approximately twice as large.

The total additional authorizations for the four types of grant authorized under title II, part 1, amount to $25 million additional Federal funds in the fiscal year ending June 30, 1966, and to approximately $60 million for the first full year of operation.

Grant-in-aid apportionments in maternal and child health program comparison of $45,000,000 appropriations with $40,000,000 appropriations[1]

State	Maternal and child health		
	$40,000,000	$45,000,000	Difference
United States	$31,437,500	$34,875,000	$3,437,500
Alabama	779,483	865,734	86,251
Alaska	149,804	159,397	9,593
Arizona	264,259	292,373	28,114
Arkansas	461,030	511,649	50,619
California	1,762,722	1,961,629	198,907
Colorado	286,293	317,624	31,331
Connecticut	340,077	378,997	38,920
Delaware	164,678	176,565	11,887
District of Columbia	198,589	215,702	17,113
Florida	1,032,535	1,147,248	114,713
Georgia	985,295	1,094,585	109,290
Guam	130,061	136,612	6,551
Hawaii	189,032	204,672	15,640
Idaho	178,101	192,056	13,955
Illinois	993,623	1,133,275	139,652
Indiana	755,822	839,872	84,050
Iowa	477,111	529,723	52,612
Kansas	345,657	383,593	37,936
Kentucky	737,641	819,161	81,520
Louisiana	824,480	915,823	91,343
Maine	242,840	269,101	26,261
Maryland	626,668	696,062	69,394
Massachusetts	586,978	652,442	65,464
Michigan	1,190,820	1,323,871	133,051
Minnesota	603,346	670,198	66,852
Mississippi	719,492	798,867	79,375
Missouri	603,268	670,248	66,980
Montana	181,665	196,169	14,504
Nebraska	258,374	286,494	28,120
Nevada	156,861	167,542	10,681
New Hampshire	174,243	187,603	13,360
New Jersey	635,288	719,709	84,421
New Mexico	243,571	269,990	26,419
New York	1,653,908	1,840,461	186,553
North Carolina	1,208,705	1,342,775	134,070
North Dakota	179,079	193,185	14,106
Ohio	1,412,888	1,570,915	158,027
Oklahoma	392,553	435,721	43,168
Oregon	304,995	338,293	33,298
Pennsylvania	1,516,164	1,685,715	169,551
Puerto Rico	972,363	1,079,920	107,557
Rhode Island	190,794	206,706	15,912
South Carolina	725,666	805,734	80,068
South Dakota	185,011	200,031	15,020
Tennessee	790,909	878,471	87,562
Texas	1,547,537	1,720,787	173,250
Utah	216,786	236,704	19,918
Vermont	154,081	164,334	10,253
Virgin Islands	125,337	131,160	5,823
Virginia	904,121	1,004,415	100,294
Washington	474,460	526,821	52,361
West Virginia	397,854	441,417	43,563
Wisconsin	655,027	727,738	72,711
Wyoming	149,555	159,111	9,556

[1] Under sec. 502(a) (fund A), from a total of $20,000,000, which is half of the appropriation, each State receives a uniform grant of $70,000 and an additional grant in proportion to the number of live births in the State. Under sec. 502(b) (fund B), from the other $20,000,000, $4,750,000 is to be used only for special projects for mentally retarded children, and $3,812,500 or 25 percent of the remaining $15,250,000 is reserved for other special projects. The remainder, $11,437,500, is apportioned so that each State receives an amount which varies directly with the number of urban and rural live births in the State and inversely with State per capita income. No State receives less than $50,000. Live births in rural areas are given twice the weight of those in urban areas.

Grants-in-aid apportionments in crippled children's program comparison of $45,000,000 appropriations with $40,000,000 appropriations [1]

State	Crippled children		
	$40,000,000	$45,000,000	Difference
United States	$32, 187, 500	$35, 625, 000	$3, 437, 500
Alabama	863, 999	952, 425	88, 426
Alaska	143, 592	152, 228	8, 636
Arizona	281, 235	310, 553	29, 318
Arkansas	531, 492	585, 446	53, 955
California	1, 590, 273	1, 821, 887	231, 614
Colorado	289, 808	320, 323	30, 515
Connecticut	339, 915	378, 811	38, 896
Delaware	162, 260	173, 773	11, 513
District of Columbia	178, 877	192, 951	14, 074
Florida	895, 936	989, 710	93, 774
Georgia	1, 024, 979	1, 130, 223	105, 244
Guam	127, 529	133, 689	6, 160
Hawaii	183, 185	197, 923	14, 738
Idaho	182, 774	198, 310	15, 536
Illinois	990, 813	1, 101, 414	110, 601
Indiana	827, 619	914, 137	86, 518
Iowa	549, 886	606, 602	56, 716
Kansas	391, 905	432, 560	40, 655
Kentucky	819, 461	903, 031	83, 570
Louisiana	810, 210	893, 668	83, 458
Maine	223, 163	245, 868	22, 705
Maryland	455, 442	504, 001	48, 559
Massachusetts	538, 290	607, 762	69, 472
Michigan	1, 201, 634	1, 329, 113	127, 479
Minnesota	654, 333	722, 413	68, 080
Mississippi	764, 518	841, 932	77, 414
Missouri	656, 958	725, 952	68, 994
Montana	182, 364	196, 976	14, 612
Nebraska	284, 935	314, 266	29, 331
Nevada	154, 259	164, 540	10, 281
New Hampshire	172, 927	186, 085	13, 158
New Jersey	641, 273	726, 617	85, 344
New Mexico	236, 033	260, 262	24, 229
New York	1, 474, 981	1, 688, 826	213, 845
North Carolina	1, 332, 455	1, 468, 283	135, 828
North Dakota	183, 254	201, 706	18, 452
Ohio	1, 455, 230	1, 609, 561	154, 331
Oklahoma	463, 581	511, 446	47, 865
Oregon	315, 483	348, 245	32, 762
Pennsylvania	1, 608, 841	1, 778, 823	169, 982
Puerto Rico	964, 873	1, 062, 703	97, 830
Rhode Island	189, 749	205, 500	15, 751
South Carolina	775, 982	854, 813	78, 831
South Dakota	192, 665	212, 111	19, 446
Tennessee	894, 080	985, 655	91, 575
Texas	1, 721, 357	1, 902. 532	181, 175
Utah	217, 034	236, 989	19, 955
Vermont	154. 669	165, 013	10, 344
Virgin Islands	123. 980	129, 593	5, 613
Virginia	928, 948	1, 024, 700	95, 752
Washington	485, 437	536, 206	50. 769
West Virginia	482. 236	531, 184	48, 948
Wisconsin	720, 633	795, 856	75, 223
Wyoming	150, 156	159, 804	9, 648

[1] Under sec. 512(a) (fund A) each State receives a uniform grant of $70,000 and an additional grant in proportion to the number of children under 21 years in the State. Under sec. 512(b) (fund B) $3,750,000 is to be used only for special projects for services for crippled children who are mentally retarded, and $4,062,500 or 25 percent of the remaining $16,250,000 is reserved for other special projects. The remainder, $12,187,500, is apportioned so that each State receives an amount which varies directly with the number of children under 21 years in urban and rural areas in the State and varies inversely with State per capita income. No State receives less than $50,000. Children in rural areas are given twice the weight of those in urban areas.

C. Implementation of Mental Retardation Planning

Under the Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (Public Law 88–156), $2.2 million was authorized to provide small grants to States for the purpose of planning comprehensive programs in the field of mental retardation. The requirements for receipt of such grants included the involvement of all types of agencies—health, education, welfare, institutions, etc.—concerned with problems of the mentally retarded. Your committee is advised that each State has submitted an application and received a grant under this program.

In order to assure that the planning which is being done has impact on State programs, your committee believes that further limited grants for purposes of followup and implementation are warranted. The bill accordingly authorizes appropriations of $2,750,000 each for the fiscal years ending June 30, 1966, and June 30, 1967, for this purpose. Each of these appropriations would be available for expenditure for the fiscal year for which it was made and for succeeding fiscal years that end prior to July 1, 1968.

D. General Discussion of Old-Age, Survivors, and Disability Insurance Provisions

(1) SEVEN-PERCENT INCREASE IN BENEFITS

Your committee believes that a benefit increase at this time is obvious. For the overwhelming majority of the 20 million people now getting social security checks—aged and disabled people and their families and orphaned children and their widowed mothers—the benefits are the major source of support; for a great many they are the only source. The last general benefit increase was enacted in 1958 and was effective with benefits payable for January 1959. Since that date there have been changes in wages, prices, and other aspects of the economy. For the aged, who generally are the most economically disadvantaged group, the combined effect of the 7-percent increase and the hospital insurance benefits will be to provide a substantial improvement in levels of living.

Under the bill monthly benefits for retired workers now on the benefit rolls who began to draw benefits at age 65 or later would range from $44 to $135.90, as compared with $40 to $127 under present law. Because of the increases that the bill would make in the contribution and benefit base, retired workers coming on the rolls in the future with benefits based on average monthly earnings of more than $400, the highest possible under present law, would of course get benefits of more than $135.90. The increases in the base, together with the benefit increase, would result in a maximum benefit for the worker of $149.90, payable on average monthly earnings of $466 (the highest possible under the $5,600 contribution and benefit base), and ultimately in a maximum benefit of $167.90, payable on the average monthly earnings of $550 that are possible under the $6,600 contribution and benefit base. The following table is illustrative of benefit amounts for various family groups under the $5,600 contribution and benefit base and under present law.

Illustrative monthly benefits payable under present law and under the committee bill with a $5,600 contribution and benefit base[1]

Average monthly earnings	Old-age benefits[2]				Survivors benefits			
	Worker		Man and wife[3]		Widow aged 62, widower, or parent		Widow and 2 children	
	Present law	Bill	Present law	Bill	Present law	Bill	Present law	Bill[4]
$67 or less	$40	$44.00	$60.00	$66.00	$40.00	$44.00	$60.00	$66.00
$100	59	63.20	88.50	94.80	48.70	52.20	88.50	94.80
$150	73	78.20	109.50	117.30	60.30	64.60	120.00	120.00
$200	84	89.90	126.00	134.90	69.30	74.20	161.70	161.70
$250	95	101.70	142.50	152.60	78.40	83.90	202.50	202.50
$300	105	112.40	157.50	168.60	86.70	92.80	236.40	240.00
$350	116	124.20	174.00	186.30	95.70	102.50	254.10	266.10
$400	127	135.90	190.50	203.90	104.80	112.20	254.10	286.80
$466	(5)	149.90	(5)	224.90	(5)	123.70	(5)	312.00

[1] A revised and extended benefit table will become effective with January 1971, to take account of average monthly earnings up to $550, the maximum average monthly earnings that will be possible under the $6,600 contribution and benefit base that will be effective for years after 1970.

[2] For a worker age 65 or over at the time of retirement and a wife age 65 or over at the time when she comes on the rolls.

[3] Survivor benefit amounts for a widow and 1 child or for 2 parents would be the same as the benefits for a man and wife.

[4] For families already on the benefit rolls who are affected by the maximum-benefit provisions, the amounts payable under the bill would in some cases be somewhat higher than those shown here.

[5] Not applicable, since the highest possible average monthly earnings amount is $400.

The family maximum.—Under the bill, the maximum amount of benefits payable to a family would be related to the worker's average monthly earnings through the entire range as it now is at the lower levels. Under present law, the highest maximum family benefit is $254, and this amount applies at all average monthly earnings levels above $314. Under the bill, a different family maximum amount would be provided at every average monthly earnings bracket in the benefit table, from a minimum of $66 to a maximum of $312 under the $5,600 contribution and benefit base and to a maximum of $368 under the $6,600 contribution and benefit base. The maximum amount payable to a family now on the benefit rolls would be $286.80, as compared with $254 under present law.

Effective date.—The 7-percent increase would be effective beginning with benefits for January 1965. The increased benefits would be paid retroactively to the 20 million beneficiaries who were on the rolls in January 1965 and to beneficiaries who came on the rolls after January 1965 and through the month of enactment of the bill whether or not they are still on the rolls at the time of enactment. Lump-sum death payments based on deaths that occurred in the retroactive period would not be increased.

This is the first time that a general increase in social security benefits has been made retroactive. The present situation may be regarded as somewhat unique. As your committee stated last July in its report on H.R. 11865, a general increase in social security benefits was needed at that time. H.R. 11865, as passed by both Houses last year, provided for a general benefit increase and, if the bill had been enacted, it would have provided increased social security benefits that would have been effective at about the beginning of 1965. For reasons not related to the question of whether benefits should be increased, H.R. 11865 failed of passage last year. Your committee therefore recommends paying

the increased benefits retroactively to January, thus putting beneficiaries in the same relative position they would have been in if H.R. 11865 had been enacted.

Because of the magnitude of the task of converting the benefit rolls to the higher amounts, the first regular monthly check reflecting the 7-percent increase generally would be the check for the third month following the month of enactment.

To avoid the possibility of confusion on the part of beneficiaries as to the exact amount of the benefit increase, the increased benefits for the retroactive months would be paid in a separate check.

In 1965, an estimated $1.2 billion in additional benefits would be paid as a result of the 7-percent increase; in 1966, $1.4 billion in additional benefits would be paid.

2. PAYMENT OF CHILD'S INSURANCE BENEFITS TO CHILDREN ATTENDING SCHOOL OR COLLEGE AFTER ATTAINMENT OF AGE 18 AND UP TO AGE 22

Under present law a child beneficiary is considered dependent, and is paid benefits, until he reaches age 18, or after that age if he was disabled before age 18 and is still disabled. The committee believes that a child over age 18 who is attending school full time is dependent just as a child under 18 or a disabled older child is dependent, and that it is not realistic to stop such a child's benefit at age 18. A child who cannot look to a father for support (because the father has died, is disabled, or is retired) is at a disadvantage in completing his education as compared with the child who can look to his father for support. Not only may the child be prevented from going to college by loss of parental support and loss of his benefits; he may even be prevented from finishing high school or going to a vocational school. With many employers requiring more than a high school education as a condition for employment, education beyond the high school level has become almost a necessity in preparing for work.

Your committee believes it is now appropriate and desirable to provide social security benefits for children between the ages of 18 and 22 who are full-time students and who have suffered a loss of parental support. Students whose benefits have already terminated at age 18, as well as children currently on the rolls, would qualify for benefits under the provision. The median age of students graduating from high school is about 18; providing benefits up to age 22 would mean that for many children benefits could continue for the time it takes to complete a 4-year college course.

The term "school" is defined broadly to permit payments to students taking vocational or academic courses. The definition of school is intended to establish that the institution the child attends is a bona fide school. It includes all public school, colleges, and universities, as well as private, accredited institutions and private nonaccredited institutions whose credits are accepted by accredited institutions. In determining full-time attendance, the Secretary of Health, Education, and Welfare would take into account the standards and practices of the school involved. Specifically excluded would be an individual paid by his employer to attend school. Benefits would be paid during normal school vacation periods as well as during the school year.

The bill would not provide for the payment of mother's benefits to a mother whose only child is over 18 and getting benefits because he is

attending school. There is less need to pay benefits to the mother in such cases than in those where the child is under 18, since she is not required to stay at home to care for the child as she may have been when he was younger.

The provision for paying benefits to children aged 18–21 who are full-time students would be effective beginning with benefits for January 1965. Benefits would be paid retroactively to children who would have been eligible in January 1965 and to those who have become eligible since that time regardless of whether they are eligible in the month in which the bill is enacted. A provision similar to this was included in H.R. 11865, 88th Congress, which failed of passage for reasons entirely unrelated to the payment of benefits to children aged 18–21 who were full-time students. Your committee recognizes that the retroactive benefit payments cannot be made immediately after this bill is enacted since there may be some delay because of administrative problems.

An estimated 295,000 children would be eligible for benefits for September 1965, when the school year begins, and in 1966 about $195 million in benefits would be paid.

3. BENEFITS FOR WIDOWS AT AGE 60

Under present law the earliest age at which a widow without eligible children can qualify for benefits based on the earnings of her deceased husband is 62. Many women are widowed years after having left the labor market to become housewives and mothers, and they lack the skills necessary to qualify for reasonably suitable employment. Women who are widowed in their late fifties and sixties are often denied employment because of their age.

The bill would provide for the payment of aged widow's benefits beginning at age 60, with the benefits actuarially reduced to take account of the longer period over which they would be paid. This provision would thus extend to these women a choice of applying for benefits at any time between age 60 and 62, with a reduced benefit, or of waiting until age 62 to receive a full widow's benefit. The amount of the reduction—five-ninths of 1 percent for each month before age 62 for which the benefit was paid—would be sufficient to assure that over the long run there will be no additional cost to the social security system as a result of the earlier payment of the benefits. If the widow chose to get her benefits starting at age 60 her benefit would be reduced by 13⅓ percent; the reduced benefit would amount to 71½ percent of the deceased husband's primary benefit (at age 62 the full benefit equals 82½ percent of the decreased husband's primary widow's benefit).

An estimated 185,000 widows aged 60–61 on the effective date of this provision are expected to claim benefits during the first year of operation. Benefit payments would be about $165 million in 1966.

4. AMENDMENTS OF DISABILITY PROGRAM

(a) Improvements in disability provisions

In 1956, Congress amended the Social Security Act to provide disability benefits for persons afflicted with disabilities of long-continued and indefinite duration and of sufficient severity to prevent a return to

any substantial gainful employment. In providing this protection against loss of earnings resulting from extended total disability, the Congress designed a conservative program. It was expected that, as experience under these provisions was gained, necessary improvements would follow. As a result, amendments enacted in 1958 and 1960 improved the disability program by, among other changes, extending benefits to wives and children of the disabled, and by providing for the payment of disability benefits to incapacitated workers under age 50 who had previously been excluded. Your committee believes that experience with the disability program since 1960 indicates that certain further improvements should be made at this time to broaden the protection provided by the program against the risk of extended total disability. The recommended improvements in the disability provisions would be adequately financed from the contributions your committee is recommending be earmarked for the disability insurance trust fund.

(1) Elimination of the long-continued and indefinite duration requirement from the definition of disability

Under present law, disability insurance benefits are payable only if the worker's disability is expected to result in death or to be of long-continued and indefinite duration. Your committee's bill would broaden the disability insurance protection afforded by the social security program by providing disability insurance benefits for an insured worker who has been totally disabled for at least 6 calendar months even though it is expected that he will recover in the foreseeable future. The modification in the definition recommended by your committee does not change, however, the requirement in existing law that an individual must by reason of his impairment be unable "to engage in any substantial gainful activity." In line with the original views expressed by your committee and since reaffirmed, to be eligible an individual must demonstrate that he is not only unable, by reason of a physical or mental impairment, to perform the type of work he previously did, but that he is also unable, taking into account his age, education, and experience, to perform any other type of substantial gainful work, regardless of whether or not such work is available to him in the locality in which he lives.

Your committee believes that the elimination of the requirement of indefinite duration from the definition of disability would help to meet the need for insurance protection of that substantially large group of disabled workers who, though totally disabled for an extended period, can be expected to eventually recover. For many of these disabled people, the payment of disability insurance benefits would mean the difference between financial independence and dependence on public assistance. Workers who contract tuberculosis, for example, can generally be expected to recover after a period of appropriate treatment. However, the period during which they may be unable to engage in any gainful work because of their condition may extend well over a year and many such workers are, during this protracted period, without the income they need to support their families. It is estimated that if benefits were payable for disabilities that are total and last more than 6 months but are not necessarily expected to last indefinitely about 155,000 additional people—workers

and their dependents—would become immediately eligible for benefits.

Your committee expects that, as now, procedures will be utilized to assure that the worker's condition will be reviewed periodically and reports of medical reexaminations obtained where appropriate so that benefits may be terminated promptly where the worker ceases to be disabled.

The elimination of the requirement that a determination be made that a disability can be expected to result in death or to be of long-continued and indefinite duration would bring the social security disability program into line with the prevailing practice in private disability insurance. Provisions much like the one which your committee is recommending, that is, providing for the payment of disability benefits on the basis of total disability throughout a continuous period of 6 months without regard to the expected duration of disability, serve as the basis for payment in the majority of private disability insurance contracts and in many other disability programs.

The elimination of the indefinite duration requirement would also clarify for beneficiaries their rights under the disability program and at the same time simplify administration and help to speed up the payment of the first benefit check to disabled workers in those cases where a medical determination about the duration of disability is difficult to make. Under present law, the need for such prognoses sometimes results in delays in filing, and occasionally in the failure to file for benefits when the applicant is uncertain about whether his disability can be expected to be permanent. In some cases, the need for a prognosis delays a determination of disability; in other cases, the application is denied initially because a favorable prognosis is made. While the prognosis may, in the latter case, ultimately prove erroneous and thus necessitate a reversal of the initial decision, payment is then made retroactively in a lump sum and not on a current basis when the benefits are most needed.

(2) Payment of a benefit for the sixth month of disability

Your committee is also recommending that entitlement to social security disability benefits begin at the end of the sixth month of continuous disability. Under the waiting period requirement in the present law, more than 7 months must pass after the onset of disability before the disabled worker can receive his first benefit check. By changing the present requirement so that the first month of entitlement to benefits would be the last month of the waiting period, the first benefit check would be payable for the sixth full month of disability. Thus, under this recommended change there would still be a wait of at least 6 months after onset of disability before the worker or his family could receive benefits, but the first disability check would be paid as quickly as possible after the 6-month waiting period.

(3) Payment of benefits for second disabilities without regard to waiting period

Your committee is also recommending a conforming modification in the provisions of present law under which disability benefits are paid without a waiting period in the case of a worker whose previous disability was terminated within 5 years before onset of his second disability. The purpose of the provision for the payment of disability benefits without regard to the waiting period in the case of a bene-

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ficiary whose disability recurs within 5 years after the termination of a prior period of disability is to encourage disabled persons to return to work even though there may be a question as to whether their work attempts will be successful. Since many disability insurance beneficiaries who return to work do so despite severe impairments and are thus faced with the possibility that their work attempts may be unsuccessful, a 6-month qualifying period for reentitlement to benefits may be a real bar to any further work attempts. Under the provision recommended by your committee, benefits would be paid beginning with the first month of onset of the second or subsequent disability and without regard to the waiting period requirement only if the individual had a prior period of disability which lasted at least 18 calendar months and only if the subsequent period of disability can be expected, at the time of application, to last a continuous period of at least 12 months or to result in death. Your committee is recommending this change in order to limit the cases in which payment of benefits would be made without a waiting period to those situations where it is reasonable to presume in general that the second or subsequent disability constitutes a recurrence or aggravation of the previous disability and where the second or subsequent disability can be expected to be of extended duration.

Concern has been expressed about the payment of disability benefits concurrently with benefits payable under State workmen's compensation laws. Your committee is advised that under the present law the extent of excessive wage replacement resulting from overlapping benefits between workmen's compensation and social security disability benefits has not been significant. Moreover, a provision in the social security law for reducing disability benefits by the amount of any other benefit to which a worker was entitled under State workmen's compensation laws, which was in effect from July 1957 to July 1958, was repealed in 1958 because it was concluded that it operated in an inequitable and unsatisfactory manner. Nevertheless, your committee shares the belief of the Advisory Council on Social Security that it would be worth while to have additional information about the overlap and its effects.

We therefore request that the Social Security Administration proceed as rapidly as feasible with plans to conduct a study of the significance of overlapping benefits under the two programs. Such a study should produce information on: (1) the number and proportion of beneficiaries under each program who are receiving cash disability benefits under the other program; (2) the characteristics of persons receiving dual benefits as compared with those not receiving dual benefits; and (3) the extent to which combined payments under the two programs are effective in replacing lost earnings, both currently and for the future. Your committee requests that a report covering the results of this study and such other facts relating to the problem as are found relevant, be made to it on or before December 31, 1966. This report should also include recommendations as to whether action (and if so, what kind of action) should be taken under the Federal social security disability program or under the State workmen's compensation programs to control excessive payments in cases of dual entitlement, as well as the effect on costs to employers.

(*b*) *Payment of disability insurance benefits after entitlement to other monthly insurance benefits*

Under the hospital insurance benefit provisions of your committee's bill, a wife who is age 65 or over and whose husband is between the age of 62 and 65 and insured can qualify for hospital insurance, provided her husband files for actuarially reduced old-age insurance benefits. The husband may be working full time and not receive any of the old-age benefits. Under present law, he would be reluctant to file for old-age benefits because present law states that after a worker becomes entitled to old-age benefits he cannot subsequently qualify for disability benefits. If present law were unchanged, the worker would be faced with the choice of sacrificing either eligibility for disability protection or his wife's health insurance.

Your committee has, therefore, included in the bill a provision whereby a worker who becomes entitled to old-age benefits may subsequently, until he reaches age 65, become entitled to disability benefits. This provision would also eliminate the difficult question some beneficiaries have faced, even before the hospital insurance question arose, as to whether they should take actuarially reduced benefits or retain their rights to disability protection.

(*c*) *Increase in allocation to the disability insurance trust fund*

The bill would increase the contribution income allocated to the disability insurance trust fund from 0.50 to three-fourths of 1 percent of taxable wages and from 0.375 to nine-sixteenths of 1 percent of taxable self-employment income. This increase takes account of lower disability termination rates than were expected (disability insurance beneficiaries have been living somewhat longer than anticipated) and the increase in the cost of the disability insurance part of the program arising out of the changes made by the bill. The increase in the contribution income to the disability fund would bring the disability insurance part of the program into close actuarial balance.

5. PAYMENT OF BENEFITS TO CERTAIN PEOPLE AGED 72 OR OVER WHO ARE NOT OTHERWISE INSURED

Your committee believes that a special transitional insured status provision should be adopted so that social security benefits can be provided for those among the present aged who, though they worked in covered jobs, did not have an opportunity to work long enough to become insured under the program, and for their wives and widows. About 355,000 people would become eligible immediately for social security benefits under these provisions, with benefits payable under the provisions totaling about $140 million in 1966.

The present law requires a minimum of six quarters of coverage for insured status; as a result, although the general requirement for insured status is one quarter of coverage for each year elapsing after 1950 and up to retirement age (65 for men, 62 for women), people who reached retirement age in 1956 or earlier must have more than one quarter for each year that elapsed after 1950 to qualify for benefits.

Under the bill the minimum would be three quarters of coverage rather than six, and therefore people who reached retirement age in 1954, 1955, or 1956 could qualify for benefits if they had one quarter of coverage for each year that elapsed after 1950 and up to retirement

age, and people who reached retirement age prior to 1954 could qualify if they had three quarters of coverage instead of six.

The following table shows the operation of the "transitional insured status" provision for workers:

Men		Women	
Age in 1965	Quarters of coverage required	Age in 1965	Quarters of coverage required
76 or over	3	73 or over	3
75	4	72	4
74	5	71	5

Wife's benefits would be payable at age 72 to a woman whose husband qualified for benefits under the transitional provision if she attained age 72 before 1969.

Widow's benefits would be payable at age 72 to a woman whose husband qualified for benefits under the transitional provision if she attained age 72 before 1969. Also, a widow whose husband had attained age 65 or died before 1957 without being insured could get benefits if the husband had a specified number of quarters of coverage, as shown in the following table:

Year of husband's death (or attainment of age 65, if earlier)	Quarters of coverage required under present law	Quarters of coverage required if the widow attains age 72 in—		
		1966 or earlier	1967	1968
1954 or before	6	3	4	5
1955	6	4	4	5
1956	6	5	5	5

Under these provisions the benefit amount for a worker would be $35 per month; for his wife, $17.50 per month; for his widow, $35 per month. Benefits would be payable for and after the second month following the month of enactment.

6. LIBERALIZATION IN THE RETIREMENT TEST

The bill would change the provision in present law under which there is a $1 reduction in benefits for each $2 of earnings above $1,200 and up to $1,700 to provide for a $1-for-$2 reduction for earnings from $1,200 to $2,400. Benefits would continue to be reduced by $1 for every $1 of earnings above $2,400, as they are now on earnings above $1,700. This change would increase the incentive to work in the income range between $1,700 and $2,400 and would, in combination with the increase in benefits that the bill also provides, make possible a significant increase in annual income for many beneficiaries who are able to work and earn more than $1,700.

Under present law a self-employed person who performs substantial services but who has no income from current work, can nevertheless have benefits withheld under the retirement test because he gets royalties attributable to a copyright or patent obtained in years before he at-

tained age 65. The bill would exclude for retirement test purposes royalties received by a self-employed person in or after the year in which he attained age 65 if those royalties are attributable to a copyright or patent obtained before the year in which he attained age 65. Royalties received by a beneficiary from a copyright or patent obtained in or after the year in which he attained age 65 would continue to be counted for retirement test purposes, as under present law, in the year in which they are received.

7. WIFE'S AND WIDOW'S BENEFITS FOR DIVORCED WOMEN

It is not uncommon for a marriage to end in divorce after many years, when the wife is too old to build up a substantial social security earnings record even if she can find a job. But under present law a wife's right to zenefits on her husband's earnings record generally ends with a divorce. Under the present social security law, the only benefits provided for a divorced woman are mother's insurance benefits, and they are payable only if she has a child of the deceased worker in her care and the child is getting benefits on the basis of his deceased father's earnings, if she has not remarried, and if she had been getting at least one-half of her support from her former husband under a court order or agreement at the time of his death. A divorced wife without a child in her care cannot get benefits even though she had been dependent upon the worker for much of his working lifetime and he was contributing to her support when he retired or died.

Under the bill wife's or widow's benefits would be payable to an aged divorced woman on the basis of her former husband's earnings if the divorced woman (A) had been married to that former husband for 20 years before the divorce, (B) had not remarried, and (C) met the following support requirement at the time her former husband became disabled, became entitled to benefits or died; (1) she was receiving one-half of her support from her former husband, or (2) she was receiving substantial contributions from him pursuant to a written agreement, or (3) a court order for substantial contributions to her support from her former husband was in effect. A conforming change would be made in the support requirements that must be met by a former wife divorced (renamed "surviving divorced mother" in the bill) in order to qualify for mother's benefits based on the social security account of her deceased former husband.

Payment of a wife's or widow's benefit to a divorced woman would not reduce the benefits paid to any other person on the same social security account and such wife's or widow's benefit would not be reduced because of other benefits payable on the same account.

The bill would also provide that a wife's benefit will not terminate when she and her husband are divorced if they had been married for at least 20 years before the divorce.

Benefits for a divorced wife or a surviving divorced wife would not terminate on account of remarriage in those cases where widow's benefits under present law do not terminate—that is, where the remarriage is to a man getting benefits as a dependent widower or parent or as a disabled child aged 18 or over. If a divorced wife or a surviving divorced wife married an old-age insurance beneficiary, her benefits would terminate but she would immediately be eligible for wife's benefit on her new husband's account.

While the provisions just described would take care of cases in which the marriage had lasted for 20 years or more, they would leave unsolved the problem of the woman who is widowed or divorced after many years and is remarried but whose second marriage ends in divorce after less than 20 years. To meet this problem, the bill would further provide that a woman whose rights to benefits as a widow, divorced wife, surviving divorced wife, or surviving divorced mother were terminated because she remarried will have her former benefit rights restored if her second marriage ends in divorce after less than 20 years. This provision would provide protection for women whose second marriages end in divorce after they are along in years. The divorced woman who was age 62 or over and getting benefits before she remarried and the divorced woman whose former husband died when she was 50 and who later remarried would be among the women protected by the provision. Young women getting mother's benefits (including surviving divorced mothers) would also have protection in case their second marriages ended in divorce. In the case of a surviving divorced mother, the provision would not preclude her possible entitlement to benefits as a surviving mother on the basis of the earnings record of a second husband to whom she was married for a period of less than 20 years prior to divorce; under present law, a woman may be entitled to benefits on a man's earnings record as his former wife divorced if she has his child in her care even if she has not been married to him for 20 years, and the bill would not change that situation.

These changes would provide protection mainly for women who have spent their lives in marriages that are dissolved when they are far along in years—especially housewives who have not been able to work and earn social security benefit protection of their own—from loss of benefit rights through divorce.

8. ADOPTION OF CHILD BY RETIRED WORKER

Under present law, a child adopted by a worker who is already retired and getting old-age insurance benefits can become entitled to benefits even though he was not dependent on the worker at the time the latter retired. In contrast, present provisions governing the payment of child's insurance benefits to a child adopted by a person getting disability insurance benefits, and to a child adopted by the surviving spouse of a worker who has died, contain requirements designed to assure that benefits will be paid to such children only when there is a basis for assuming that the child lost a source of support when the worker became disabled or died.

Your committee believes that the provisions concerning adoptions by retired workers should be made comparable to those relating to adoptions in other cases so as to provide safeguards against abuse through adoption of children solely to qualify them for benefits, and has included in the bill a provision that would accomplish this result. Under this provision benefits would be payable to a child who is adopted by an old-age insurance beneficiary after the latter becomes entitled to benefits only if the following conditions are met:

(1) At the time the worker became entitled to benefits the child was living with the worker or adoption proceedings had begun;

(2) The adoption was completed within 2 years of the time when the worker became entitled to benefits; and

(3) The child had been receiving at least one-half of his support from the worker for the entire year before the worker became entitled to old-age insurance benefits or, if the worker had a period of disability which continued until be became entitled to old-age insurance benefits, before the beginning of the period of disability.

9. COVERAGE EXTENSIONS AND MODIFICATIONS

Your committee's bill would extend social security coverage to self-employment income from the practice of medicine, and to the wages of interns, cover tips as wages, facilitate coverage of additional State and local government employees, provide additional coverage for employees of certain nonprofit organizations, extend coverage to temporary employees of the District of Columbia, increase the amount of gross income which farmers may use under the optional method of computing farm self-employment income for social security purposes, and permit exemption from the social security self-employment tax for persons who follow certain teachings of a religious sect of which they are members.

(*a*) *Coverage of self-employed physicians and interns*

Self-employed doctors of medicine are the only group of significant size whose self-employment income is excluded from coverage under social security. Large numbers of doctors have requested coverage. Your committee knows of no valid reason why this single professional group should continue to be excluded. It runs counter to the general view that coverage should be as universal as possible. There are no technical or administrative barriers to the coverage of self-employed doctors of medicine.

Moreover, more than half of the physicians in private practice have obtained some social security credits through work other than their self-employment as physicians, or through their military service. As indicated, many requests for coverage have been received from those who have not obtained social security credits in this way and from physicians who have some credits but wish to obtain full social security protection.

Your committee's bill would cover the self-employment income of the approximately 170,000 self-employed doctors of medicine on the same basis as the self-employment income of other professional groups, effective for taxable years ending after December 31, 1965.

Coverage would also be extended to services performed by medical and dental interns. The coverage of services as an intern would give young doctors an earlier start in building up social security protection and would help many of them to become insured under the program at the time when they need the family survivor and disability protection it provides. This protection is important for doctors of medicine who, like members of other professions, in the early years of their practice, may not otherwise have the means to provide adequate survivorship and disability protection for themselves and their families. Interns would be covered on the same basis as other employees working for the same employers, beginning on January 1, 1966.

(b) Computation of self-employment income from agriculture

Under present law, persons with net earnings from farm self-employment have the following option in reporting for social security purposes: (*a*) If annual gross income from agricultural self-employment is not over $1,800, either actual net earnings or 66⅔ percent of gross income may be reported; (*b*) if gross income from agricultural self-employment is over $1,800 and net earnings are less than $1,200, either net earnings or $1,200 (two-thirds of $1,800) may be reported; and (*c*) if the annual gross income is more than $1,800 and net earnings are $1,200 or more, actual net earnings must be reported.

The bill approved by your committee would retain the present option in the reporting of farm self-employment income but would raise the level of income which may be reported under the gross income option by increasing the $1,800 figure to $2,400 and the $1,200 figure to $1,600.

Thus, persons with agricultural self-employment would be permitted to use the following option in reporting their earnings from agricultural self-employment for social security purposes: (*a*) If annual gross income from agricultural self-employment is not over $2,400, either actual net earnings or 66⅔ percent of gross income may be reported; (*b*) if gross income from agricultural self-employment is over $2,400 and actual net earnings are less than $1,600, either actual net earnings or $1,600 may be reported; and (*c*) if gross earnings are more than $2,400 and net earnings are more than $1,600, the actual net earnings must be reported. This change would be effective for taxable years beginning after December 31, 1965.

(c) Coverage of tips

The problem of extending social security coverage to tips has engaged the attention of your committee for many years. The principal difficulty has been to devise a fair and practical system for obtaining information on amounts of tips received by an individual which could serve as a basis for contributions and benefit credits. Another problem has been the question of whether tips should be taxed as wages or as self-employment income.

It is a matter of common knowledge that in occupations where employees customarily receive tips, the regular wages of these employees are generally far below those of other employees with comparable training and duties. It was reported to the committee, for example, that under a bargaining agreement covering hotel employees in a large city the wages of waiters and waitresses were about 30 percent under those of a dishwasher, one of the lowest paid kitchen workers, and the wages of bellhops were one-half of those of reservation clerks. On the basis of such wage and tipping practices, the committee has concluded that it would be appropriate to treat tips as wages for social security purposes.

The committee has also decided that the only equitable way of counting tips toward benefits is on the basis of actual amounts of tips received and that the only practical way to get this information is to require employees to report their tips to the employer. Other methods for determining a tax and credit base for tips were considered previously, but the agencies directly concerned with the problems concluded that no other approach would assure better coverage

or compliance. Your committee agrees with this and has adopted in this bill the reporting plan approved last year in H.R. 11865.

On the average about one-third of the work income of employees who receive tips in the course of employment is in the form of tips; for many, tips constitute the major source of earnings. Since the regular wages of employees who customarily receive tips are relatively low, the benefits based on those wages are low. For example, under the benefit provisions of the bill, a person getting regular wages of $35 a week and averaging another $35 in tips would get a monthly retirement benefit, beginning at age 65, of $79.20 if only his regular wages were counted. If his tips could also be counted, his benefit amount would be $113.50.

Coverage of tips will provide better protection under the social security program for more than a million employees and their dependents. The amount of tips received by employees who regularly receive tips is estimated at more than $1 billion a year. Under existing law, only a small fraction of this amount may now be counted toward social security. Information has been presented to indicate that only a small fraction of this amount is now reported for income tax purposes. Because the extension of social security coverage to tips should result in better reporting of all tips for income tax purposes, it seems only fair to allow employees whose earnings are principally from tips to use the pay-as-you-go (withholding) system for paying the income tax on their tips and to have employers collect this tax from the regular wages. Your committee's bill, therefore, provides for the collection of income tax from wages on tips reported to the employer.

Under the bill, tips received by an employee (on his own behalf) in the course of his employment would be covered as wages. The employee would be required to report to his employer in writing the amount of tips received and the employer would report the employee's tips along with the employee's regular wages. The employee's report to his employer would include tips paid to him through the employer as well as those received directly from customers of the employer. To avoid requiring employees and employers to report small amounts of tips that might be burdensome on employers and that would not ordinarily have a significant effect on the employee's benefit amount, tips received by an employee which do not amount to a total of $20 a month in connection with his work for any one employer would not be covered and would not be reported.

The employer would be responsible for collecting the employee's share of the social security tax on tips, paying his (the employer's) share of the tax, and including the tips with his report of wages only if the employee reported the tips to him, in writing, within 10 days after the end of the month in which the tips were received, and then only to the extent that he had available unpaid cash wages of the employee, or funds the employee turned over to him for that purpose, that were sufficient to cover the employee's share of the tax. As a convenience to the employer, a provision is included under which he would be permitted to withhold the employee's share of the social security tax from current wages on the basis of an estimated amount of tips and to adjust the amount withheld at the end of each quarter to conform to the amount actually due on the basis of the employee's written statement of his tips. This provision will permit the employer

to gear these new reporting procedures into his usual payroll periods. The amount of tips reported by the employer for the employee in his quarterly report of wages paid to employees would, of course, be the amount of tips which the employee reported to his employer for the calendar quarter and on which the employer could withhold the employee's share of the social security tax. Also, provision is made authorizing an employer who is furnished a written statement of tips to deduct from the employee's wages the employee's tax on the tips included in the statement, even though at the time the statement is furnished the total amount of tips received so far in the month is less than $20.

Although the employer would have no liability with respect to tips which were not reported to him within the time specified in the bill and with respect to which he could not collect the employee tax out of unpaid wages of, or funds turned over by, the employee, such tips, nevertheless, would be covered. In such case, the employee would be liable for the employee's share of the social security tax and—unless he could show reasonable cause for failure to provide the employer with a written statement of his tips and make available to the employer the employee's share of the tax due on such tips—an additional amount equal to that tax.

The bill further provides that the employees' tips are to be subject to income tax withholding. Under present income tax law, tips are considered compensation for services and are includible in gross income. Your committee is advised that a very substantial number of tip recipients do not report all their tips, and that many report none at all. For example, in a recent survey conducted by the Internal Revenue Service covering 154 tip employees in 5 restaurants and 2 hotels of a large northern city, practically all employees had reported only their regular wages and no tips on their tax returns. One-third of these employees have since agreed to tax deficiencies averaging $450. The others have been assessed deficiencies averaging $600 per taxpayer. In the opinion of your committee, if tips are to be covered under social security as wages they should also be treated as wages for purposes of the collection of tax at source.

Under present law, employees who receive tips should be paying the income tax due on their tips on an estimated quarterly basis as do other taxpayers who receive income from sources where the income tax is not collected by the payer. It is a difficult problem for the average tip recipient to comply with this requirement in the law because of the informal manner in which he receives numerous tips. But even if compliance could be expected, the payment in one lump sum at 3-month intervals of the estimated tax due on tips received during such 3-month period would be a considerable burden on these employees, the great majority of whom are in the lower income brackets and would have difficulty in budgeting to pay these quarterly amounts. A proper, convenient and easy solution is to offer these employees the opportunity to pay their income tax on tips currently by having the employer withhold the tax from the employee's regular wages.

In general, the employer would follow the same procedures for income tax withholding as for social security purposes. The employer's liability for withholding income tax, however, would be limited to funds of the employee that are in the employer's possession before the close of the calendar year in which the tips were received and that are

in excess of the amount of social security taxes to be collected. There would be no obligation on the part of the employee to ensure that the employer had sufficient funds of the employee to be able to deduct the full amount of the income tax required to be withheld. In most instances the employee's wages would be more than adequate to cover the social security tax and the income tax withholding. A weekly wage of only $12 for a single person would be more than enough to cover the social security and income taxes due on combined tip and wage earnings of $62. This would represent tips at a rate of $1.25 an hour for a 40-hour week which are above average earnings since 60 percent of waiters and waitresses in the United States earn under $1.25 an hour in tips, according to a 1961 Bureau of Labor Statistics survey.

Tips received by self-employed people are covered under present law as income from self-employment for social security purposes. In providing this method for covering tips received by employees it is not intended that this action of the committee change the employment status of any one who receives tips or change the treatment of tips received by the self-employed.

(*d*) *Coverage provisions applying to employees of States and localities*

(*1*) *Addition of Alaska and Kentucky to the States which may provide coverage through division of retirement systems*

Under a provision of the Social Security Act which is designed to facilitate the extension of social security coverage to members of State and local government retirement systems, 18 specified States (and all interstate instrumentalities) are permitted to divide a State or local government retirement system into two parts for purposes of social security coverage, one part consisting of the positions of members who desire coverage, and the other consisting of the positions of members who do not desire coverage. Services performed by employees in the part consisting of the positions of members who desire coverage may then be covered under social security, and once those services are covered, the services of all persons who in the future become members of the retirement system must also be covered. The 18 States which are now permitted to extend coverage under this provision are California, Connecticut, Florida, Georgia, Hawaii, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin. Your committee's bill would add Alaska and Kentucky to this group of States.

(*2*) *Facilitating coverage under the provision for division of State and local government retirement systems*

The bill would provide a further opportunity for election of social security coverage by employees of States and localities who did not elect coverage when they previously had the opportunity to do so under the provision permitting specified States to cover only those members of a retirement system who desire coverage. Under the present provision, the specified States may, during the 2-year period after coverage of a group is approved, cover additional employees who request coverage. (However, employees hired after coverage of the group is originally approved are covered on a compulsory basis.) The bill would reopen, or hold open, through December 31, 1966, the opportunity for election of coverage by those employees who had not elected

coverage before the expiration of the 2-year period following approval of the coverage of their group.

Your committee recognizes that employees who initially failed to elect coverage under the divided retirement system provision were provided two subsequent opportunities for election of coverage under amendments made to the Social Security Act in 1958 and 1961. Although in general it is important that the time limits for electing coverage be maintained and that it be known they will be maintained, this situation involves special circumstances which seem to your committee to justify providing one additional opportunity. Your committee believes, however, that in the future there should be no further reopening of the opportunity for electing coverage under the divided retirement system provision beyond that which would be provided under this bill. We urge that those now contemplating participation in the program take timely action to exercise their choice.

The social security coverage of employees obtaining coverage as a result of the further opportunity provided by the proposed amendment would be required to begin on the same date as was provided when their group was originally covered.

(3) Coverage for certain additional hospital employees in California

The bill would modify a provision of the Social Security Amendments of 1960 which made coverage under the social security program available to certain hospital employees in the State of California who had performed services at some time during the period from January 1, 1957, through December 31, 1959, with respect to which contributions had been erroneously paid to the Internal Revenue Service prior to July 1, 1960. The 1960 legislation provided for crediting the remuneration which had been erroneously reported during the 1957–59 period, and for covering the services performed after 1959 by the individuals for whom the erroneous reportings had been made. Your committee's bill would make it possible for the State to provide coverage, beginning with January 1, 1962, for the services of hospital employees employed in the positions in question after 1959, and to secure the crediting of remuneration erroneously reported for them for periods prior to 1962 if contributions with respect to such remuneration have been paid before the enactment of the bill. The State would have 6 months after the month of enactment in which to provide such coverage.

The individuals who would be affected by your committee's bill could not be covered under the 1960 legislation, since they were not in the group for which erroneous reports had been filed during the 1957 through 1959 period. And, like the employees to whom the 1960 legislation applied, they cannot be covered under the generally applicable provisions of the Social Security Act providing coverage for employees of States and localities.

Generally speaking, the Social Security Act does not permit States to bring under social security coverage persons whom the States have removed from coverage under a State and local retirement system. The positions of the employees in question were removed from coverage under the California State employees retirement system effective July 1, 1957, without awareness that this section established a bar to future social security coverage. This misunderstanding led to the erroneous reports, and created the need for the 1960 amendment.

The employees to whom the bill is directed have the same need for coverage as those to whom the 1960 legislation applied, and are barred from coverage under the general provisions of law in the same way as were the employees covered by the 1960 legislation. Your committee believes that they should be given the same opportunity to obtain protection under the social security program as was given in 1960 to hospital employees in a similar situation.

(e) *Tax exemption for members of a religious group opposed to insurance*

Your committee's bill would permit exemption from the social security self-employment tax of individuals who have conscientious objections to insurance (including social security) by reason of their adherence to the established tenets or teachings of a religious sect (or division thereof) of which they are members. The exemption could be granted with respect to taxable years beginning after December 31, 1950.

The sect (or division thereof) must be one that has been in existence at all times since December 31, 1950, and has for a substantial period of time been making reasonable provision for its dependent members. To qualify as grounds for the tax exemption, the objections of the individual and the sect (or division thereof) to insurance must include objections to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act). Before an individual could be granted exemption he would be required to waive all benefits and other payments under any insurance system established by the Social Security Act on the basis of his own earnings as well as all such benefits and other payments to him based onthe earnings of any other person. The exemption could not be granted to any person who has been entitled to social security benefits, or to one whose earnings have provided the basis for entitlement to social security benefits for any other person. An individual's exemption (and the waiver of social security benefits) would be terminated if, and as of the time, the conditions under which the exemption was granted are no longer met, and the individual could not again be granted an exemption.

Your committee believes that provisions for coverage under social security on an individual voluntary basis are undesirable, and we have been reluctant to recommend an amendment which would permit an individual to elect exemption from social security coverage. Present law provides no exemption by reason of an individual's religious beliefs. The voluntary coverage provisions for ministers are applicable only to ministerial services; a minister who does other work is covered on the same basis as any other person. We believe that an exemption from social security taxes with respect to work that is generally covered would be justifiable only in cases where it is amply clear that an individual cannot accept the benefits of insurance, including social security benefits, without renouncing basic tenets of his religion. The exemption we are recommending is designed to be granted in only such cases. The proposed exemption would be limited to the self-employment tax under social security since those persons

for whom the payment of social security taxes appears to be irreconcilable with their religious convictions also, by reason of their religious beliefs, limit their work almost entirely to farming and to certain other self-employment.

We believe that the proposed exemption must be on the basis of individual choice. To exclude all members of a religious group from social security coverage would not take account of the variances in individual beliefs within any religious group, and would deny social security protection to those individuals who want it. Among the Old Order Amish, for example, there have been some indications of a change in attitude toward social security, particularly among the younger people; some members of the Old Order Amish who have become eligible for social security benefits have claimed the benefits.

Your committee believes that the recommended provision would provide relief for those individuals who sincerely believe that payment of social security taxes is irreconcilable with their religious convictions. We strongly recommend against any broadening of the proposed amendment since any such broadening could well lead to widespread individual voluntary coverage under social security, which would undermine the soundness of the social security program.

(*f*) *Additional retroactive coverage of nonprofit organizations, and validation of coverage of certain employees of such organizations*

Under present law the employees of a nonprofit organization may be covered under social security only if the employing organization files a certificate waiving its exemption from social security coverage. Your committee has learned that in some cases organizations have been reporting their employees for social security purposes without ever having filed the required waiver certificate. Such reports may be submitted for some time before the organization learns that they are erroneous. In such cases, employees who have been counting on having social security protection on the basis of their employment with such organization may in fact not have that protection.

Your committee's bill would permit a nonprofit organization to elect social security coverage to be effective for a period of up to 5 years (rather than 1 year, as under present law) before the calendar quarter in which the waiver certificate electing social security is filed. In addition, nonprofit organizations which had filed a waiver certificate in or prior to the year in which the bill is enacted would be given until the end of the year following enactment to amend their certificate to make social security coverage effective for a period of up to 5 years before the calendar quarter in which the amendment to the waiver certificate is filed.

Thus, by making its waiver certificate sufficiently retroactive, a nonprofit organization that had been erroneously reporting earnings for its employees without having filed a certificate to elect coverage could ordinarily provide complete and continuous social security coverage for the erroneously reported employees. That is, a nonprofit organization which learns of its erroneous reporting could file a certificate electing coverage and make it sufficiently retroactive to cover the period for which employee earnings already reported would otherwise be stricken from the record because the statute of limitations had not run when the erroneous reporting had been discovered. The effect of the social security statute of limitations is that in most cases correction of

an employee's social security earnings record may be made only if the error is discovered within 3 years, 3 months, and 15 days following the end of the year in which the wages were erroneously paid. Your committee's bill would, then, resolve on a permanent basis troublesome problems which have arisen under the nonprofit coverage provisions.

Your committee's bill also amends section 105(b) of the Social Security Amendments of 1960, which provided that an employee of a nonprofit organization could, under certain circumstances, receive credit for erroneously reported wages. The amendment applies to employees who are no longer in the employ of an organization when the waiver certificate is filed. These persons cannot be covered under the general provisions for retroactive coverage, as retroactive coverage is available only to persons still in the employ of an organization when the waiver certificate is filed. The amendment would permit such employees to have validated the reports of wages which had erroneously been made for them by the organization during the period of retroactive coverage. These persons have the same need for social security protection as those who are still employed by the organization when it files its waiver certificate.

(*g*) *Coverage of certain employees of the District of Columbia*

Under the present provisions of the Social Security Act, all service performed in the employ of the District of Columbia is excluded from social security coverage. Most District employees are covered under the Federal civil service retirement system or one of the two District retirement systems. Substitute teachers, however, are not covered under any government retirement system. Under your committee's bill, the District of Columbia could provide social security coverage for them. In addition, the bill would make it possible for the District of Columbia to cover under social security temporary or intermittent employees who are not now covered under the civil service retirement system but because of the temporary nature of their employment. The earliest date on which coverage could become effective would be the first day of the calendar quarter following the calendar quarter of enactment.

(*h*) *Special study relating to Federal employees*

The Committee on Ways and Means is aware that the single largest group of our citizens whose employment by law is precluded from social security coverage are the employees of the Federal Government. Your committee has given attention to this problem from time to time over a period of several years. Extensive consideration was given in 1960 to extending some form of social security coverage to Federal employees. At that time, it was concluded, on the recommendation of the Department of Health, Education, and Welfare and the Social Security Administration, that further opportunity should be afforded to the departments and agencies of the executive branch to give further study to the matter and present a coordinated recommendation to the Congress. Therefore, in lieu of statutory action, the Committee on Ways and Means at that time, in its report on the bill which became the Social Security Amendments of 1960 (H. Rept. 1799, to accompany H.R. 12580, 86th Cong.) urged the interested departments and agencies of the executive branch to "accelerate their efforts in finding a workable and sound solution to this problem and report it to the Congress at the earliest opportunity."

The report which was requested by the committee in 1960 regrettably was not received until a few days ago. Obviously, there was inadequate time on the part of the committee to study fully the suggestions contained in the report. The committee did not include provisions in this legislation in view of the lack of adequate time to study the report just presented to it.

Your committee has been advised by the Department of Health, Education, and Welfare that the executive branch has initiated a comprehensive study of retirement provisions for Federal personnel and that this study is to include further consideration of the proper role which should be played by social security, the civil service retirement program, and other staff retirement programs in the protection afforded Federal personnel.

In the light of all the foregoing, your committee has agreed to withhold recommendations until this further study is received despite the interest of many Members in closing this gap in the protection of civil service employees compared to that of employees in private industry. Your committee was advised that this study would be completed not later than December 1, 1965. It your committee's expectation that that time table will be met.

10. EXTENSION OF PERIOD FOR FILING PROOF OF SUPPORT AND APPLICATION FOR LUMP-SUM DEATH PAYMENT

The law provides that the proof of support required for husband's, widower's and parent's insurance benefits, and applications for lump-sum death payments, must be filed within a 2-year period specified in the law. An extension of an additional 2 years is allowed where there was good cause for failure to file within the initial 2-year period. Many instances have arisen where there has been failure to file the required documents within the time allowed. A number of private bills have been proposed, and some enacted, to except specific individuals from this requirement in the law.

Believing that it is more desirable to provide for these situations by a provision of general law, your committee has included an amendment under which, if it is shown to the satisfaction of the Secretary of Health, Education, and Welfare that there was good cause for failure to file within the initial 2-year period, an applicant would be allowed to file proof of support or an application for a lump-sum death payment at any time.

11. AUTOMATIC RECOMPUTATION OF BENEFITS

Under the bill provision is made for automatic annual recomputation of benefits to take account of earnings that a beneficiary may have after he comes on the rolls and that would increase his benefit amount. Under present law, benefit recomputations to take account of additional earnings generally are available only on application, and can be made only if the worker had covered earnings of more than $1,200 in a calendar year after he became entitled to benefits.

Experience has shown that a large number of people who are eligible for benefit recomputations to take account of additional earnings, and who will profit from such recomputations, fail to apply for them. Automatic recomputation would assure the beneficiary that he will get

credit for any earnings that would increase his benefit amount. Your committee has been advised that with the improved electronic equipment that is now used to compute benefit amounts, it is both feasible and administratively advantageous to handle these recomputations on an automatic basis.

An additional effect of the change would be to assure that no one would be disadvantaged by applying for benefits at age 65 instead of waiting until a somewhat later age. Under present law, in some few cases a worker who delays the filing of his application gets a larger benefit than he would have gotten if he had applied at age 65. In certain situations, therefore, people do not know whether to apply for benefits or to defer filing. Sometimes they do apply and it turns out to have been disadvantageous. Under the provisions in the bill it will be possible to assure every claimant that he cannot lose by applying at age 65.

12. REIMBURSEMENT OF THE TRUST FUNDS FOR THE COST OF MILITARY SERVICE CREDITS

Military service was not covered under the social security program on a contributory basis until 1957. However, special benefits were provided for the survivors of World War II veterans who died within 3 years after discharge, and noncontributory wage credits were provided under the program for active military service from September 16, 1940, through December 1956. The old-age and survivors insurance trust fund has been reimbursed for the cost of the benefits paid through August 1950, in the amount of about $15 million. However, although present law provides that the costs incurred through June 30, 1956, were to have been paid into the trust funds over the 10 fiscal years ending June 30, 1969, and that the costs incurred by the payment of such benefits after June 1956 were to have been appropriated annually, no such payments have been made.

Your committee believes that it would be desirable to amortize the amounts owing over a period longer than the 10-year period provided under present law. The bill would authorize a level annual appropriation from general revenues to the trust funds starting in fiscal year 1966, that would amortize both the accumulated backlog and the additional amounts that will accrue through fiscal year 2015. After 2015, annual appropriations would be authorized to pay any additional costs.

13. FINANCING PROVISIONS

(a) Increase in the contribution and benefit base

The bill would raise from $4,800 to $5,600, beginning with 1966, and to $6,600, beginning with 1971, the limitation on the amount of annual earnings that is used in determining benefits and that is subject to tax for the support of the program. The increases in the contribution and benefit base will make it possible to provide, for workers at and above average earnings levels, benefits that are more reasonably related to their actual earnings, and, by taxing a larger proportion of the Nation's growing payrolls, will improve the financial base of the program.

Even though higher benefits are provided on the basis of the additional earnings that are taxed and credited for social security pur-

poses, an increase in the contribution and benefit base results in a reduction in the overall cost of the social security program as a percent of taxable payrolls.

(*b*) *Changes in the contribution rates*

Consistent with the policy of maintaining the program on a financially sound basis that has always been followed in the past, the bill makes full provision for meeting the cost of the improvements it would make in the OASDI programs. Additional income would result from increasing the earnings base to $5,600 in 1966 and $6,600 in 1971 and from the extensions of coverage provided under the bill. In addition, your committee is recommending a revised contribution rate schedule.

Your committee has paid particular attention to the effect social security taxes might have on the individual taxpayer and the economy as a whole. Therefore, the schedule of contribution rates included in the bill, while it will produce sufficient income to finance the social security program, at the same time will avoid increases in the trust funds at a time when the economic impact of trust fund increases would be uncertain. Under the schedule of rates your committee recommends, no contribution rate increase after 1966 would go into effect at the same time as a contribution base increase, and the tax rate increase for old-age, survivors, and disbility insurance scheduled to go into effect in 1966 would be somewhat lower than the one scheduled under the present law. Also, old-age, survivors, and disability insurance contributions for the self-employed person would be held at 6.0 percent of self-employment income through 1968 rather than increasing to 6.1 percent in 1966 and to 6.9 percent in 1968; after 1973 the contribution rate for the self-employed would be only one-tenth of 1 percent higher than scheduled under present law.

The present and proposed contribution rates for old-age, survivors, and disability insurance are as follows:

Year	Contribution rates (in percent)			
	Employer and employee, each		Self-employed	
	Present law	Bill	Present law	Bill
1966–67	4.125	4.0	6.2	6.0
1968	4.625	4.0	6.9	6.0
1969–72	4.625	4.4	6.9	6.6
1973 and after	4.625	4.8	6.9	7.0

14. ADVISORY COUNCIL ON SOCIAL SECURITY

The bill would repeal the present provisions for the appointment of future Advisory Councils on Social Security Financing and provide instead for the appointment of Advisory Councils of broader scope and of somewhat different representation.

The Councils provided for under present law are, in general, required to report only on the financing of the program. The Council that was appointed in 1963 and made its report on January 1 of this year was the only Council required to present its findings and recommendations with respect to all aspects of the program. That Council

urged that "every 5 years or so Advisory Councils be formed to review the substantive provisions of the program as well as its financing." Your committee agrees with this recommendation, and under the bill the scope of future Advisory Councils would be broadened so that all future Councils would report on all aspects of the program (including the new hospital insurance and supplementary health insurance programs established under the bill) and on their impact on the public assistance programs.

Present law requires that the Councils be composed of 12 members representing employers and employees in equal numbers and self-employed persons and the public. The bill provides that the Council members shall, to the extent possible, represent employer and employee organizations in equal numbers and self-employed persons and the public.

The Councils would submit their reports to the Secretary of Health, Education, and Welfare for transmission to the Congress and to the Board of Trustees. Under the time schedule for the appointment of Advisory Councils now in the law, Councils are to be appointed in 1966 and every fifth year thereafter and report on January 1 of the second year after the year of appointment. This schedule was designed so that a Council would report 1 year before each tax increase, and every fifth year after the final increase. In 1961 the final tax increase, previously scheduled for 1969, was rescheduled for 1968. As a result, the Council to be appointed in 1966 is required to make its report on the day on which the final rate increase now in the law is scheduled to go into effect. Under the bill, the next Advisory Council would be appointed in 1968 and make its report not later than January 1, 1970. Subsequent Councils would be appointed so as to report in 1975 and every fifth year thereafter.

15. ACTUARIAL COST ESTIMATES FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

(a) *Summary of actuarial cost estimates*

The old-age, survivors, and disability insurance system, as modified by your committee's bill, has an estimated cost for benefit payments and administrative expenses that is very closely in balance with contribution income. This also was the case for the 1950 and subsequent amendments at the time they were enacted.

The old-age and survivors insurance system as modified by your committee's bill has been shown to be not quite self-supporting under the intermediate-cost estimate. Nevertheless, there is close to an exact balance, especially considering that a range of variation is necessarily present in the long-range actuarial cost estimates and, further, that rounded tax rates are used in actual practice. Accordingly, the old-age and survivors insurance program, as it would be changed by your committee's bill, is actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows a favorable actuarial balance of 0.04 percent of taxable payroll under the provisions that would be in effect after enactment of your committee's bill, because the contribution rate allocated to this fund is slightly more than the cost of the disability benefits, based on the intermediate-cost estimate. Considering the

variability of cost estimates for disability benefits, this small actuarial surplus is not significant. The disability insurance program, as it would be modified by your committee's bill, is actuarially sound.

(b) Financing policy

(1) Contribution rate schedule for old-age, survivors, and disability insurance in bill

The contribution schedule for old-age, survivors, and disability insurance contained in your committee's bill is lower than that under present law by 0.25 percent in the combined employer-employee rate in 1966–67, is lower by 1.25 percent in 1968, is lower by 0.45 percent in 1969–72, and is higher by 0.35 percent in 1973 and thereafter. The maximum earnings base to which these tax rates are applied is $5,600 per year for 1966–70 and $6,600 for 1971 and after under your committee's bill as compared with $4,800 under present law. These tax schedules are as follows:

[Percent]

Calendar year	Present law		Committee bill	
	Employee rate (same for employer)	Self-employed rate	Employee rate (same for employer)	Self-employed rate
1965	3.625	5.4	3.625	5.4
1966–67	4.125	6.2	4.0	6.0
1968	4.625	6.9	4.0	6.0
1969–72	4.625	6.9	4.4	6.6
1973 and after	4.625	6.9	4.8	7.0

The allocation rates to the two trust funds that are applicable to the combined employer-employee contribution rate for the bill, as compared with present law, are as follows:

[Percent]

Calendar year	Old-age and survivors insurance		Disability insurance	
	Present law	Committee bill	Present law	Committee bill
1965	6.75	6.75	0.50	0.50
1966–67	7.75	7.25	.50	.75
1968	8.75	7.25	.50	.75
1969–72	8.75	8.05	.50	.75
1973 and after	8.75	8.85	.50	.75

(2) Self-supporting nature of system

The Congress has always carefully considered the cost aspects of the old-age, survivors, and disability insurance system when amendments to the program have been made. In connection with the 1950 amendments, the Congress stated the belief that the program should be completely self-supporting from the contributions of covered individuals and employers. Accordingly, in that legislation the provision permitting appropriations to the system from general revenues of the Treasury was repealed. This policy has been continued in subsequent amendments. The Congress has always very strongly believed that the tax schedule in the law should make the system self-supporting as nearly as can be foreseen and actuarially sound.

(3) Actuarial soundness of system

The concept of actuarial soundness as it applies to the old-age, survivors, and disability insurance system differs considerably from this concept as it applies to private insurance and private pension plans, although there are certain points of similarity with the latter. In connection with individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system and, moreover, is not always the case for well-administered private pension plans, which may not have funded all the liability for prior service benefits.

It can reasonably be presumed that, under Government auspices, such a social insurance system will continue indefinitely into the future. The test of financial soundness, then, is not a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather, the test is whether the expected future income from tax contributions and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs. Thus, the concept of "unfunded accrued liability" does not by any means have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is quite proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group. These additional assets and liabilities must be considered in order to determine whether the system is in actuarial balance.

Accordingly, it may be said that the old-age, survivors, and disability insurance program is actuarially sound if it is in actuarial balance. This will be the case if the estimated future income from contributions and from interest earnings on the accumulated trust fund investments will, over the long run, support the disbursements for benefits and administrative expenses. Obviously, future experience may be expected to vary from the actuarial cost estimates made now. Nonetheless, the intent that the system be self-supporting (and actuarially sound) can be expressed in law by utilizing a contribution schedule that, according to the intermediate-cost estimate, results in the system being in balance or substantially close thereto.

Your committee believes that it is a matter for concern if the old-age, survivors, and disability insurance system shows any significant actuarial insufficiency. Traditionally, the view has been held that for the old-age and survivors insurance portion of the program, if such actuarial insufficiency has been no greater than 0.25 percent of payroll, when measured over perpetuity, it is at the point where it is within the limits of permissible variation. The corresponding point for the disability insurance portion of the system is about 0.05 percent of payroll (lower because of the relatively smaller financial magnitude of this program). Based on the recommendation of the 1963–64 Advisory Council on Social Security Financing (see app. V of the 25th Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, H. Doc. No. 100, 89th Cong.), the cost estimates are now being made on a 75-year basis, rather than on a perpetuity basis. On this approach, the margin of variation from exact balance should be smaller—no more than 0.10 percent of

taxable payroll for the combined old-age, survivors, and disability insurance program.

Furthermore, traditionally when there has been an actuarial insufficiency exceeding the limits indicated, any subsequent liberalizations in benefit provisions were fully financed by appropriate changes in the tax schedule or through raising the earnings base, and at the same time the actuarial status of the program was improved.

The changes provided in your committee's bill are in conformity with these financing principles.

(*c*) *Basic assumptions for cost estimates*

(*1*) *General basis for long-range cost estimates*

Benefit disbursements may be expected to increase continuously for at least the next 50 to 70 years because of such factors as the aging of the population of the country and the slow but steady growth of the benefit roll. Similar factors are inherent in any retirement program, public or private, that has been in operation for a relatively short period. Estimates of the future cost of the old-age, survivors and disability insurance program are affected by many elements that are difficult to determine. Accordingly, the assumptions used in the actuarial cost estimates may differ widely and yet be reasonable.

The long-range cost estimates (shown for 1975 and thereafter) are presented on a range basis so as to indicate the plausible variation in future costs depending upon the actual trends developing for the various cost factors. Both the low- and high-cost estimates are based on assumptions that are intended to represent close to full employment, with average annual earnings at about the level prevailing in 1963. The use of 1963 average earnings results in conservatism in the estimate since the trend is expected to be an increase in average earnings in future years (as will be discussed subsequently in item 5). In 1963, the aggregate amount of earnings taxable under the program was $226 billion. Of course, when new workers enter the labor force in years after 1963, the total taxable earnings increase simply because of multiplying the larger number of covered workers by the 1963 average earnings rates. In addition to the presentation of the cost estimates on a range basis, intermediate estimates developed directly from the low- and high-cost estimates (by averaging their components) are shown so as to indicate the basis for the financing provisions.

The cost estimates are extended beyond the year 2000, since the aged population itself cannot mature by then. The reason for this is that the number of births in the 1930's was very low as compared with subsequent experience. As a result, there will be a dip in the relative proportion of the aged from 1995 to about 2010, which would tend to result in low benefit costs for the old-age, survivors, and disability insurance system during that period. For this reason the year 2000 is by no means a typical ultimate year insofar as costs are concerned.

(*2*) *Measurement of costs in relation to taxable payroll*

In general, the costs are shown as percentages of covered payroll. This is the best measure of the financial cost of the program. Dollar figures taken alone are misleading. For example, a higher earnings level will increase not only the outgo of the system but also, and to

a greater extent, its income. The result is that the cost relative to payroll will decrease. As an illustration of the foregoing points, consider an individual who has covered earnings at a rate of $300 per month. Under your committee's bill such an individual would have a primary insurance amount of $112.40. If his earnings rate should increase by 50 percent (to $450), his primary insurance amount would be $145.90. Under these conditions, the contributions payable with respect to his earnings would increase by 50 percent, but his benefit rate would increase by only 30 percent. Or to put it another way, when his earnings rate was $300 per month, his primary insurance amount represented 37.5 percent of his earnings, whereas, when his earnings increased to $450 per month, his primary insurance amount relative to his earnings decreased to 32.4 percent.

(3) *General basis for short-range cost estimates*

The short-range cost estimates (shown for the individual years 1965–72) are not presented on a range basis since—assuming a continuation of present economic conditions—it is believed that the demographic factors involved (such as mortality, fertility, retirement rates, etc.) can be reasonably closely forecast, so that only a single estimate is necessary. A gradual rise in the earnings level in the future, paralleling that which has occurred in the past few years, is assumed. As a result of this assumption, contribution income is somewhat higher than if level earnings were assumed, while benefit outgo is only slightly affected.

The cost estimates have been prepared on the basis of the same assumptions and methodology as those contained in the 25th Annual Report of the Board of Trustees (H. Doc. No. 100, 89th Cong.).

(4) *Level-cost concept*

An important measure of long-range cost is the level-equivalent contribution rate required to support the system for the next 75 years (including not only meeting the benefit costs and administrative expenses, but also the maintenance of a reasonable contingency fund during the period, which at the end of the period amounts to 1 year's disbursements), based on discounting at interest. If such a level rate were adopted, relatively large accumulations in the old-age and survivors insurance trust fund would result, and in consequence there would be sizable eventual income from interest. Even though such a method of financing is not followed, this concept may be used as a convenient measure of long-range costs. This is a valuable cost concept, especially in comparing various possible alternative plans and provisions, since it takes into account the heavy deferred benefit costs.

(5) *Future earnings assumptions*

The long-range estimates for the old-age, survivors, and disability insurance program are based on level-earnings assumptions, under which earnings levels of covered workers by age and sex will continue over the next 75 years at the levels experienced in 1963. This, however, does not mean that covered payrolls are assumed to be the same each year; rather, they are assumed to rise steadily as the

population at the working ages is estimated to increase. If in the future the earnings level should be considerably above that which now prevails, and if the benefits are adjusted upward so that the annual costs relative to payroll will remain the same as now estimated for the present system, then the increased dollar outgo resulting will offset the increased dollar income. This is an important reason for considering costs relative to payroll rather than in dollars.

The long-range cost estimates have not taken into account the possibility of a rise in earnings levels, although such a rise has characterized the past history of this country. If such an assumption were used in the cost estimates, along with the unlikely assumption that the benefits, nevertheless, would not be changed, the cost relative to payroll would, of course, be lower.

It is important to note that the possibility that a rise in earnings levels will produce lower costs of the old-age, survivors, and disability insurance program in relation to payroll is a very important safety factor in the financial operations of this system. The financing of the system is based essentially on the intermediate-cost estimate, along with the assumption of level earnings; if experience follows the high-cost assumptions, additional financing will be necessary. However, if covered earnings increase in the future as in the past, the resulting reduction in the cost of the program (expressed as a percentage of taxable payroll) will more than offset the higher cost arising under experience following the high-cost estimate. If the latter condition prevails, the reduction in the relative cost of the program coming from rising earnings levels can be used to maintain the actuarial soundness of the system, and any remaining savings can be used to adjust benefits upward (to a lesser degree than the increase in the earnings level). The possibility of future increases in earnings levels should be considered only as a safety factor and not as a justification for adjusting benefits upward in anticipation of such increases.

If benefits are adjusted currently to keep pace with rising earnings trends as they occur, the year-by-year costs as a percentage of payroll would be unaffected. If benefits are increased in this manner, the level-cost of the program would be higher than now estimated, since, under such circumstances, the relative importance of the interest receipts of the trust funds would gradually diminish with the passage of time. If earnings and benefit levels do consistently rise, thorough consideration will need to be given to the financing basis of the system because then the interest receipts of the trust funds will not meet as large a proportion of the benefit costs as would be anticipated if the earnings level had not risen.

(6) Interrelationship with railroad retirement system

An important element affecting old-age, survivors, and disability nsurance costs arose through amendments made to the Railroad

Retirement Act in 1951. These provide for a combination of railroad retirement compensation and old-age, survivors, and disability insurance covered earnings in determining benefits for those with less than 10 years of railroad service (and also for all survivor cases).

Financial interchange provisions are established so that the old-age and survivors insurance trust fund and the disability insurance trust fund are to be placed in the same financial position in which they would have been if railroad employment had always been covered under the program. It is estimated that over the long range the net effect of these provisions will be a relatively small loss to the old-age, survivors, and disability insurance system since the reimbursements from the railroad retirement system will be somewhat smaller than the net additional benefits paid on the basis of railroad earnings

(7) Reimbursement for costs of military service wage credits

Another important element affecting the financing of the program arose through legislation in 1956 that provided for reimbursement from general revenues for past and future expenditures in respect to the noncontributory credits that had been granted for persons in military service before 1957. The cost estimates contained here reflect the effect of these reimbursements (which are included as contributions), based on the assumption that the required appropriations will be made in the future in accordance with the relevant provisions of your committee's bill. These reimbursements would be made on the basis of constant annual amounts (although adjusted in accordance with actual experience) over the next 50 years, rather than on the basis of the actual disbursements each year, as under present law.

(d) Actuarial balance of program in past years

(1) Status after enactment of 1952 act

The actuarial balance under the 1952 act [1] was estimated, at the time of enactment, to be virtually the same as in the estimates made at the time the 1950 act was enacted, as shown in table E. This was the case, because the estimates for the 1952 act took into consideration the rise in earnings levels in the 3 years preceding the enactment of that act. This factor virtually offset the increased cost due to the benefit liberalizations made. New cost estimates made 2 years after the enactment of the 1952 act indicated that the level-cost (i.e., the average long-range cost, based on discounting at interest, relative to taxable payroll) of the benefit disbursements and administrative expenses was somewhat more than 0.5 percent of payroll higher than the level equivalent of the scheduled taxes (including allowance for interest on the existing trust fund).

[1] The term "1952 act" (and similar terms) is used to designate the system as it existed after the enactment of the amendments of that year.

TABLE E.—*Actuarial balance of old-age, survivors, and disability insurance program under various acts for various estimates, intermediate-cost basis*

[Percent]

Legislation	Date of estimate	Level-equivalent [1]		
		Benefit costs [2]	Contributions	Actuarial balance [3]
		Old-age, survivors, and disability insurance [4]		
1935 act	1935	5.36	5.36	----------
1939 act	1939	5.22	5.30	+0.08
1939 act (as amended in the 1940's) [5]	1950	4.45	3.98	−.47
1950 act	1950	6.20	6.10	−.10
1950 act	1952	5.49	5.90	+.41
1952 act	1952	6.00	5.90	−.10
1952 act	1954	6.62	6.05	−.57
1954 act	1954	7.50	7.12	−.38
1954 act	1956	7.45	7.29	−.16
1956 act	1956	7.85	7.72	−.13
1956 act	1958	8.25	7.83	−.42
1958 act	1958	8.76	8.52	−.24
1958 act	1960	8.73	8.68	−.05
1960 act	1960	8.98	8.68	−.30
1961 act	1961	9.35	9.05	−.30
1961 act	1963	9.33	9.02	−.31
1961 act (perpetuity basis)	1964	9.36	9.12	−.24
1961 act (75-year basis)	1964	9.09	9.10	+.01
1965 bill (House)	1965	9.44	9.36	−.08
		Old-age and survivors insurance [4]		
1956 act	1956	7.43	7.23	−0.20
1956 act	1958	7.90	7.33	−.57
1958 act	1958	8.27	8.02	−.25
1958 act	1960	8.38	8.18	−.20
1960 act	1960	8.42	8.18	−.24
1961 act	1961	8.79	8.55	−.24
1961 act	1963	8.69	8.52	−.17
1961 act (perpetuity basis)	1964	8.72	8.62	−.10
1961 act (75-year basis)	1964	8.46	8.60	+.14
1965 bill (House)	1965	8.73	8.61	−.12
		Disability insurance [4]		
1956 act	1956	0.42	0.49	+0.07
1956 act	1958	.35	.50	+.15
1958 act	1958	.49	.50	+.01
1958 act	1960	.35	.50	+.15
1960 act	1960	.56	.50	−.06
1961 act	1961	.56	.50	−.06
1961 act	1963	.64	.50	−.14
1961 act (perpetuity basis)	1964	.64	.50	−.14
1961 act (75-year basis)	1964	.63	.50	−.13
1965 bill (House)	1965	.71	.75	+.04

[1] Expressed as a percentage of effective taxable payroll, including adjustment to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate. Estimates prepared before 1964 are on a perpetuity basis, while those prepared after 1964 are on a 75-year basis. The estimates prepared in 1964 are on both bases (see text).

[2] Including adjustments (*a*) to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate, (*b*) for the interest earnings on the existing trust fund, (*c*) for administrative expense costs, and (*d*) for the net cost of the financial interchange provisions with the railroad retirement system.

[3] A negative figure indicates the extent of lack of actuarial balance. A positive figure indicates more than sufficient financing, according to the particular estimate.

[4] The disability insurance program was inaugurated in the 1956 act so that all figures for previous legislation are for the old-age and survivors insurance program only.

[5] The major changes being in the revision of the contribution schedule; as of the beginning of 1950, the ultimate combined employer-employee rate scheduled was only 4 percent.

NOTE.—The figures for the 1950 act and for the 1952 act according to the 1952 estimates have been revised as compared with those presented previously, so as to place them on a comparable basis with the later figures.

(2) Status after enactment of 1954 act

The 1954 amendments as passed by the House of Representatives contained an adjusted contribution schedule that not only met the increased cost of the benefit changes in the bill, but also reduced the aforementioned lack of actuarial balance to the point where, for all practical purposes, it was sufficiently provided for. The bill as it passed the Senate, however, contained several additional liberalized benefit provisions without any offsetting increase in contribution income. Accordingly, although the increased cost of the new benefit provisions was met, the "actuarial insufficiency" as then estimated for the 1952 act was left substantially unchanged under the Senate-approved bill. The benefit costs for the 1954 amendments as finally enacted fell between those of the House- and Senate-approved bills. Accordingly, under the 1954 act, the increase in the contribution schedule met all the additional cost of the benefit changes and at the same time reduced substantially the actuarial insufficiency that the then-current estimates had indicated in regard to the financing of the 1952 act.

(3) Status after enactment of 1956 act

The estimates for the 1954 act were revised in 1956 to take into account the rise in the earnings level that had occurred since 1951–52, the period that had been used for the earnings assumptions for the estimates made in 1954. Taking this factor into account reduced the lack of actuarial balance under the 1954 act to the point where, for all practical purposes, it was nonexistent. The benefit changes made by the 1956 amendments were fully financed by the increased contribution income provided. Accordingly, the actuarial balance of the system was unaffected.

Following the enactment of the 1956 legislation, new cost estimates were made to take into account the developing experience; also, certain modified assumptions were made as to anticipated future trends. In 1956–57, there were very considerable numbers of retirements from among the groups newly covered by the 1954 and 1956 amendments, so that benefit expenditures ran considerably higher than had previously been estimated. Moreover, the analyzed experience for the recent years of operation indicated that retirement rates had risen or, in other words, that the average retirement age had dropped significantly. This may have been due, in large part, to the liberalizations of the retirement test that had been made in recent years—so that aged persons were better able to effectuate a smoother transition from full employment to full retirement. The cost estimates made in early 1958 indicated that the program was out of actuarial balance by somewhat more than 0.4 percent of payroll.

(4) Status after enactment of 1958 act

The 1958 amendments recognized this situation and provided additional financing for the program—both to reduce the lack of actuarial balance and also to finance certain benefit liberalizations made. In fact, one of the stated purposes of the legislation was "to improve the actuarial status of the trust funds." This was accomplished by introducing an immediate increase (in 1959)in the combined employer-employee contribution rate, amounting to 0.5 percent, and by advancing the subsequently scheduled increases so that they would occur at 3-year intervals (beginning in 1960) instead of at 5-year intervals.

The revised cost estimates made in 1958 for the disability insurance program contained certain modified assumptions that recognized the emerging experience under the new program. As a result, the moderate actuarial surplus originally estimated was increased somewhat, and most of this was used in the 1958 amendments to finance certain benefit liberalizations, such as inclusion of supplemental benefits for certain dependents and modification of the insured status requirements.

(5) Status after enactment of 1960 act

At the beginning of 1960, the cost estimates for the old-age, survivors, and disability insurance system were reexamined and were modified in certain respects. The earnings assumption had previously been based on the 1956 level, and this was changed to reflect the 1959 level. Also, data first became available on the detailed operations of the disability provisions for 1956, which was the first full year of operation that did not involve picking up "backlog" cases. It was found that the number of persons who meet the insured status conditions to be eligible for these benefits had been significantly overestimated. It was also found that the disability incidence experience for eligible women was considerably lower than had been originally estimated, although the experience for men was very close to the intermediate estimate. Accordingly, revised assumptions were made in regard to the disability insurance portion of the program. As a result, the changes made by the 1960 amendments could, according to the revised estimates, be made without modifying the financing provisions.

(6) Status after enactment of 1961 act

The changes made by the 1961 amendments involved an increased cost that was fully met by the changes in the financing provisions (namely, an increase in the combined employer-employee contribution rate of one-fourth of 1 percent, a corresponding change in the rate for the self-employed, and an advance in the year when the ultimate rates would be effective—from 1969 to 1968). As a result, the actuarial balance of the program remained unchanged.

Subsequent to 1961, the cost estimates were further reexamined in the light of developing experience. The earnings assumption was changed to reflect the 1963 level, and the interest-rate assumption used was modified upward to reflect recent experience. At the same time, the retirement-rate assumptions were increased somewhat to reflect the experience in respect to this factor. The further developing disability experience indicated that costs for this portion of the program were significantly higher than previously estimated (because benefits are not being terminated by death or recovery as rapidly as had been originally assumed). Accordingly, the actuarial balance of the disability insurance program was shown to be in an unsatisfactory position, and this has been recognized by the Board of Trustees, who recommended that the allocation to this trust fund should be increased

(while, at the same time, correspondingly decreasing the allocation to the old-age and survivors insurance trust fund, which under present law is estimated to be in satisfactory actuarial balance even after such a reallocation).

(*e*) *Intermediate-cost estimates*

(*1*) *Purposes of intermediate-cost estimates*

The long-range intermediate-cost estimates are developed from the low- and high-cost estimates by averaging them (using the dollar estimates and developing therefrom the corresponding estimates relative to payroll). The intermediate-cost estimate does not represent the most probable estimate, since it is impossible to develop any such figures. Rather, it has been set down as a convenient and readily available single set of figures to use for comparative purposes.

The Congress, in enacting the 1950 act and subsequent legislation, was of the belief that the old-age, survivors, and disability insurance program should be on a completely self-supporting basis and actuarially sound. Therefore, a single estimate is necessary in the development of a tax schedule intended to make the system self-supporting. Any specific schedule will necessarily be somewhat different from what will actually be required to obtain exact balance between contributions and benefits. This procedure, however, does make the intention specific, even though in actual practice future changes in the tax schedule might be necessary. Likewise, exact balance cannot be obtained from a specific set of integral or rounded tax rates increasing in orderly intervals, but rather this principle of self-support should be aimed at as closely as possible.

(*2*) *Interest rate used in cost estimates*

The interest rate used for computing the level-costs for your committee's bill is 3½ percent for the intermediate-cost estimate. This is somewhat above the average yield of the investments of the trust funds at the end of 1964 (about 3.13 percent), but is below the rate currently being obtained for new investments (about 4⅛ percent).

(*3*) *Actuarial balance of OASDI system*

Table E has shown that according to the latest cost estimates made for the 1961 act there is an almost exact actuarial balance for the combined old-age, survivors, and disability insurance system, but that there is a deficit of 0.13 percent of taxable payroll for the disability insurance portion, and a favorable balance of 0.14 percent of taxable payroll for the old-age and survivors insurance portion.

Under your committee's bill, the benefit changes proposed would be approximately financed by the increases in the contribution rates and the earnings base.

Table F traces through the change in the actuarial balance of the system from its situation under the 1961 act, according to the latest estimate, to that under your committee's bill, by type of major changes involved.

TABLE F.—*Changes in actuarial balance of old-age, survivors, and disability insurance system, expressed in terms of estimated level-cost as percentage of taxable payroll, by type of change, intermediate-cost estimate, present law and committee bill, based on 3.50 percent interest*

[Percent]

Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of present system	+0.14	−0.13	+0.01
Earnings base increase from $4,800 to $5,600–$6,600	+.48	+.04	+.52
Revised contribution schedule	−.03	+.25	+.22
Extensions of coverage	+.03		+.03
7-percent benefit increase [1]	−.59	−.05	−.64
Earnings test liberalization	−.04		−.04
Child's benefits to age 22 if in school	−.10	−.02	−.12
Reduced widow's benefits at age 60 [2]			
Disability definition revision [3]		−.05	−.05
Transitional insured status for certain persons aged 72 and over	−.01		−.01
Total effect of changes in bill	−.26	+.17	−.09
Actuarial balance under bill	−.12	+.04	−.08

[1] Includes also the effect of the minimum increase of $4 in the primary insurance amount. The 7-percent increase does not apply beyond the first $400 of average monthly wage; the same benefit factor underlying present law for average monthly wages in excess of $110 applies for that portion of the average monthly wage above $400.

[2] Includes also the cost of the provisions for paying benefits to certain divorced women.

[3] Includes the provision for permitting the payment of disability benefits after the individual has first become entitled to some other benefit.

The changes made by your committee's bill would reasonably maintain the actuarial position of the old-age, survivors, and disability insurance system. The estimated favorable actuarial balance of 0.01 percent of taxable payroll for the present system would be slightly changed—to a lack of balance of 0.08 percent, which is below the established limit within which the system is considered substantially in actuarial balance.

It should be emphasized that in 1950 and in subsequent amendments, the Congress did not recommend that the system be financed by a high level tax rate in the future, but rather recommended an increasing schedule, which, of necessity, ultimately rises higher than such a level rate. Nonetheless, this graded tax schedule will produce a considerable excess of income over outgo for many years so that a sizable trust fund will develop, although not as large as would arise under an equivalent level tax rate. This fund will be invested in Government securities (just as is also the case for the trust funds of the civil service retirement, railroad retirement, national service life insurance, and U.S. Government life insurance systems). The resulting interest income will help to bear part of the higher benefit costs of the future.

(*4*) *Level-costs of benefits, by type*

The level-cost of the old-age and survivors insurance benefits (without considering administrative expenses and the effect of interest earnings on the existing trust fund) under the 1961 act, according to the latest intermediate-cost estimate, is about 8.51 percent of taxable payroll on the 75-year basis and the corresponding figure for the program as it would be modified by your committee's bill is 8.78 percent. The corresponding figures for the disability benefits are 0.62 percent for the 1961 act and 0.70 percent for your committee's bill.

Table G presents the benefit costs for the old-age, survivors, and disability insurance system as it would be after enactment of your committee's bill, separately for each of the various types of benefits.

TABLE G.—*Estimated level-cost of benefit payments, administrative expenses, and interest earnings on existing trust fund under the old-age, survivors, and disability insurance system, after enactment of committee bill, as percentage of taxable payroll,*[1] *by type of benefit, intermediate-cost estimate at 3.50 percent interest*

[Percent]

Item	Old-age and survivors insurance	Disability insurance
Primary benefits	6.20	0.57
Wife's benefits	.50	.04
Widow's benefits	1.10	(2)
Parent's benefits	.01	(2)
Child's benefits	.67	.09
Mother's benefits	.15	(2)
Lump-sum death payments	.11	(2)
Total benefits	8.74	.70
Administrative expenses	.13	.03
Railroad retirement financial interchange	.04	.00
Interest on existing trust fund [3]	−.18	.02
Net total level-cost	8.73	.71

[1] Including adjustment to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate.
[2] This type of benefit is not payable under this program.
[3] This item includes reimbursement for additional cost of noncontributory credit for military service and is taken as an offset to the benefit and administrative expense costs.

The level contribution rate equivalent to the graded schedules in the law may be computed in the same manner as level costs of benefits. These are shown in table E, as are also figures for the net actuarial balances.

(5) OASI income and outgo in near future

Under your committee's bill, old-age and survivors insurance benefit disbursements for the calendar year 1965 will be increased by about $1.3 billion, since the effective dates for the benefit changes are January 1965 for the 7-percent benefit increase and child's benefits to age 22 while in school, and the second month after the month of enactment for most of the other changes. There will, of course, be no additional income during 1965, since the allocation rate increase and the change in the earnings base are effective on January 1, 1966.

In calendar year 1965, benefit disbursements under the old-age and survivors insurance system as modified by your committee's bill will total about $17.0 billion. At the same time, contribution income for old-age and survivors insurance in 1965 will amount to about $16.0 billion under your committee's bill, the same as under present law. Thus, benefit outgo under your committee's bill will exceed contribution income by about $1.0 billion, whereas under present law, contribution income is estimated to exceed benefit outgo by about $370 million. The size of the old-age and survivors insurance trust fund under your committee's bill will, on the basis of this estimate, decrease by about $1.2 billion in 1965 (interest receipts are somewhat less than the outgo for administrative expenses and for transfers to the railroad retirement account); under present law, it is estimated that this trust fund would increase by about $250 million as between the beginning and the end of 1965.

In 1966, benefit disbursements under the old-age and survivors insurance system as it would be modified by your committee's bill will be about $18.3 billion, or an increase of about $1.8 billion over present law. Contribution income for old-age and survivors insurance under your committee's bill for 1966 will be $18.5 billion, or about the same as present law. Accordingly, in 1966, there will be an excess of contribution income over benefit outgo of about $200 million under your committee's bill. There will be an excess of contributions over benefit outgo of about $500 million in 1967 and about $400 million in 1968.

Under the system as modified by your committee's bill, according to this estimate, the old-age and survivors insurance trust fund will be about the same size at the end of 1966 as at the beginning of the year. It will then increase by about $240 million in 1967 and $140 million in 1968, reaching $18.3 billion at the end of 1968. In the next 2 years, as a result of the scheduled increase in the contribution rate in 1969, the trust fund will increase by about $2 billion each year.

(6) DI income and outgo in near future

Under the disability insurance system, as it would be affected by your committee's bill in calendar year 1965, benefit disbursements will total about $1,620 million, and there will be an excess of benefit disbursements over contribution income of about $440 million. In 1966 and the years immediately following, contribution income will be well in excess of benefit outgo (as a result of the increased allocation to this trust fund, and the increased taxable earnings base, as provided by your committee's bill).

The disability insurance trust fund is estimated to decrease by about $490 million in 1965 under your committee's bill, as compared with a corresponding decrease of about $330 million under present law; the greater decrease results primarily from the retroactive 7-percent benefit increase. The trust fund at the end of 1966 will be about the same size as at the beginning of the year, but after 1966 it will increase in every year.

(7) Increases in benefit disbursements in 1966, by cause

The total benefit disbursements of the old-age, survivors, and disability insurance system would be increased by about $2.1 billion in 1966 as a result of the changes that your committee's bill would make. Of this amount, about $1.4 billion results from the 7-percent benefit increase, $195 million from the benefit payments to children aged 18–21 who are in full-time school attendance, $165 million from the benefit payments to widows aged 60–61, $140 million from the liberalization of the insured-status provisions for certain persons aged 72 and over, $105 million from the liberalization of the definition of disability, and $65 million from the liberalization of the earnings test (the corresponding figure for this change for subsequent years will be about twice as large).

(8) Long-range operations of OASI trust fund

Table H gives the estimated operation of the old-age and survivors insurance trust fund under the program as it would be changed by your committee's bill for the long-range future, based on the intermediate-cost estimate. It will, of course, be recognized that the

figures for the next two or three decades are the most reliable (under the assumption of level-earnings trends in the future) since the populations concerned—both covered workers and beneficiaries—are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty—if for no reason other than the relative difficulty in predicting future birth trends—but it is desirable and necessary nonetheless to consider these long-range possibilities under a social insurance program that is intended to operate in perpetuity.

TABLE H.—*Progress of old-age and survivors insurance trust fund under system as modified by committee bill, intermediate-cost estimate at 3.50 percent interest* [3]

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [2]	Interest on fund [1]	Balance in fund at end of year [3]
	Actual data					
1951	$3,367	$1,885	$81	----------	$417	$15,540
1952	3,819	2,194	88	----------	365	17,442
1953	3,945	3,006	88	----------	414	18,707
1954	5,163	3,670	92	−$21	447	20,576
1955	5,713	4,968	119	−7	454	21,663
1956	6,172	5,715	132	−5	526	22,519
1957	6,825	7,347	[4] 162	−2	556	22,393
1958	7,566	8,327	[4] 194	124	552	21,864
1959	8,052	9,842	184	282	532	20,141
1960	10,866	10,677	203	318	516	20,324
1961	11,285	11,862	239	332	548	19,725
1962	12,059	13,356	256	361	526	18,337
1963	14,541	14,217	281	423	521	18,480
1964	15,689	14,914	296	403	569	19,125
	Estimated data (short-range estimate)					
1965	$16,014	$16,987	$350	$399	$565	$17,968
1966	18,472	18,250	375	411	546	17,950
1967	19,714	19,180	361	497	567	18,193
1968	20,325	19,943	367	466	592	18,334
1969	22,920	20,785	375	475	642	20,261
1970	24,011	21,634	383	452	740	22,543
1971	25,936	22,546	391	428	866	25,980
1972	27,186	23,392	399	408	1,026	29,993
	Estimated data (long-range estimate)					
1975	$28,399	$24,440	$390	$307	$1,105	$36,829
1980	30,659	28,362	431	129	1,770	56,137
1990	35,090	36,105	510	−24	2,519	77,348
2000	40,701	40,407	559	−78	3,039	93,807
2025	50,507	61,411	769	−107	3,771	111,872

[1] An interest rate of 3.50 percent is used in determining the level-costs, but in developing the progress of the trust fund a varying rate in the early years has been used, which is equivalent to such fixed rate.

[2] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

[3] Not including amounts in the railroad retirement account to the credit of the old-age and survivors insurance trust fund. In millions of dollars, these amounted to $377 for 1953, $284 for 1954, $163 for 1955, $60 for 1956, and nothing for 1957 and thereafter.

[4] These figures are artificially high because of the method of reimbursements between this trust fund and the disability insurance trust fund (and, likewise, the figure for 1959 is too low).

NOTE.—Contributions include reimbursement for additional cost of noncontributory credit for military service.

In every year after 1965 for the next 20 years, contribution income under the system as it would be modified by your committee's bill is estimated to exceed old-age and survivors insurance benefit disburse-

ments. Even after the benefit-outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the long-range cost estimate (with a level-earnings assumption), reaching $36 billion in 1975, $56 billion in 1980, and over $90 billion at the end of this century. In the very far distant future, namely, in about the year 2015, the trust fund is estimated to reach a maximum of about $150 billion.

(9) Long-range operations of DI trust fund

The disability insurance trust fund, under the program as it would be changed by your committee's bill, grows slowly but steadily after 1966, according to the intermediate long-range cost estimate, as shown by table I. In 1975, it is shown as being $3.5 billion, while in 1990, the corresponding figure is $9.3 billion. There is a small excess of contribution income over benefit disbursements for every year after 1965.

TABLE I.—*Progress of disability insurance trust fund under system as modified by committee bill, intermediate-cost estimate at 3.50 percent interest* [1]

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [2]	Interest on fund [1]	Balance in fund at end of year
	Actual data					
1957	$702	$57	[3] $3	----------	$7	$649
1958	966	249	[3] 12	----------	25	1,379
1959	891	457	50	−$22	40	1,825
1960	1,010	568	36	−5	53	2,289
1961	1,038	887	64	5	66	2,437
1962	1,046	1,105	66	11	68	2,368
1963	1,099	1,210	68	20	66	2,235
1964	1,154	1,309	79	19	64	2,047
	Estimated data (short-range estimate)					
1965	$1,187	$1,624	$85	$20	$50	$1,555
1966	1,840	1,784	110	20	46	1,527
1967	2,044	1,880	119	20	46	1,598
1968	2,109	1,959	124	15	47	1,656
1969	2,177	2,017	128	15	50	1,723
1970	2,246	2,069	132	15	53	1,806
1971	2,426	2,126	135	15	58	2,014
1972	2,543	2,174	139	15	67	2,296
	Estimated data (long-range estimate)					
1975	$2,412	$2,146	$103	−$3	$109	$3,502
1980	2,604	2,346	106	−11	159	5,014
1990	2,980	2,630	107	−14	300	9,270
2000	3,456	3,096	120	−14	541	16,442
2025	4,289	4,230	156	−14	1,237	36,958

[1] An interest rate of 3.50 percent is used in determining the level-costs, but in developing the progress of the trust fund a varying rate in the early years has been used, which is equivalent to such fixed rate.

[2] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

[3] These figures are artifically low because of the method of reimbursements between the trust fund and the old-age and survivors insurance trust fund (and, likewise, the figure for 1959 is too high).

NOTE.—Contributions include reimbursement for additional cost of noncontributory credit for military service.

(f) Cost estimates on range basis

(1) Long-range operations of trust funds

Table J shows the estimated operation of the old-age and survivors insurance trust fund under the program as it would be changed by your committee's bill for low- and high-cost estimates, while table K gives corresponding figures for the disability insurance trust fund.

Under the low-cost estimate, the old-age and survivors insurance trust fund builds up quite rapidly and in the year 2000 is shown as being about $260 billion and is then growing at a rate of about $16 billion a year. Likewise, the disability insurance trust fund grows steadily under the low-cost estimate, reaching about $9 billion in 1980 and $38 billion in the year 2000, at which time its annual rate of growth is about $2 billion. For both trust funds, under these estimates, benefit disbursements do not exceed contribution income in any year after 1965 for the foreseeable future.

TABLE J.—*Estimated progress of old-age and survivors insurance trust fund under system as modified by committee bill, low- and high-cost estimates*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year
	Low-cost estimate					
1975	$29,035	$23,966	$361	$287	$1,513	$46,828
1980	31,621	27,538	398	104	2,625	77,292
1990	37,422	34,376	469	−54	5,101	145,892
2000	44,618	37,871	515	−113	9,178	260,977
	High-cost estimate					
1975	$27,789	$24,915	$418	$327	$780	$27,126
1980	29,691	29,186	464	154	1,069	35,932
1990	32,753	37,834	550	6	363	12,504
2000	36,780	42,943	603	−43	[3]	[3]

[1] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

[2] At interest rates of 3.75 percent for the low-cost estimate and 3.25 percent for the high-cost estimate.

[3] Fund exhausted in 1993.

NOTE.—Contributions include reimbursement for additional cost of noncontributory credit for militsry service.

TABLE K.—*Estimated progress of disability insurance trust fund under system as modified by committee bill, low- and high-cost estimates*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year
	Low-cost estimate					
1975	$2,463	$2,001	$94	−$6	$195	$5,765
1980	2,685	2,174	95	−15	314	9,124
1990	3,177	2,428	94	−19	689	19,651
2000	3,788	2,899	103	−19	1,337	37,684
	High-cost estimate					
1975	$2,361	$2,291	$112		$37	$1,294
1980	2,522	2,517	117	−$7	28	1,054
1990	2,782	2,832	120	−9	[3]	[3]
2000	3,124	3,293	137	−9	[3]	[3]

[1] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.
[2] At interest rates of 3.75 percent for the low-cost estimate and 3.25 percent for the high-cost estimate.
[3] Fund exhausted in 1988.

NOTE.—Contributions include reimbursement for additional cost of noncontributory credit for military service.

On the other hand, under the high-cost estimate the old-age and survivors insurance trust fund builds up to a maximum of about $36 billion in about 15 years, but decreases thereafter until it is exhausted shortly before the year 2000. Under this estimate, benefit disbursements from the old-age and survivors insurance trust fund are lower than contribution income during all years after 1965 and before 1981.

As to the disability insurance trust fund, under the high-cost estimate, in the early years of operation the contribution income is about the same as the benefit outgo. Accordingly, the disability insurance trust fund, as shown by this estimate, will be about $1.5 billion during the first few years after 1965 and will then slowly decrease until it is exhausted in 1988.

The foregoing results are consistent and reasonable, since the system on an intermediate-cost-estimate basis is intended to be approximately self-supporting, as indicated previously. Accordingly, a low-cost estimate should show that the system is more than self-supporting, whereas a high-cost estimate should show that a deficiency would arise later on. In actual practice, under the philosophy in the 1950 and subsequent acts, as set forth in the committee reports therefor, the tax schedule would be adjusted in future years so that none of the developments of the trust funds shown in tables J and K would ever eventuate. Thus, if experience followed the low-cost estimate, and if the benefit provisions were not changed, the contribution rates would probably be adjusted downward—or perhaps would not be increased in future years according to schedule. On the other hand, if the experience followed the high-cost estimate, the contribution rates would have to be raised above those scheduled. At any rate, the high-cost estimate does indicate that, under the tax schedule adopted, there will be ample funds to meet benefit disbursements for several decades, even under relatively high-cost experience.

(2) Benefit costs in future years relative to taxable payroll

Table L shows the estimated costs of the old-age and survivors insurance benefits and of the disability insurance benefits under the program as it would be changed by your committee's bill as a percentage of taxable payroll for various future years, through the year 2040, and also the level-costs of the two programs for the low-, high-, and intermediate-cost estimates (as was previously shown in tables E and G for the intermediate-cost estimate).

TABLE L.—*Estimated cost of benefits of old-age, survivors, and disability insurance system as percent of taxable payroll,*[1] *under system as modified by committee bill*

[In percent]

Calendar year	Low-cost estimate	High-cost estimate	Intermediate-cost estimate [2]
	Old-age and survivors insurance benefits		
1975	7.33	7.95	7.64
1980	7.72	8.70	8.20
1990	8.14	10.24	9.12
2000	7.52	10.35	8.80
2025	8.65	13.78	10.76
2040	9.81	14.81	11.78
Level-cost [3]	7.64	10.13	8.73
	Disability insurance benefits		
1975	0.61	0.73	0.67
1980	.61	.75	.68
1990	.57	.77	.66
2000	.57	.79	.67
2025	.65	.86	.74
2040	.70	.91	.78
Level-cost [3]	.64	.82	.71

[1] Taking into account the lower contribution rate for the self-employed, as compared with the combined employer-employee rate.

[2] Based on the averages of the dollar contributions and dollar costs under the low-cost and high-cost estimates.

[3] Level contribution rate, at an interest rate of 3.25 percent for high-cost, 3.50 percent for intermediate-cost, and 3.75 percent for low-cost, for benefits after 1964, taking into account interest on the trust fund on December 31, 1964, future administrative expenses, the railroad retirement financial interchange provisions, the reimbursement of military-wage-credits cost, and the lower contribution rates payable by the self-employed.

Your committee believes that it would be desirable to amortize the amounts owing over a period longer than the 10-year period provided under present law. The bill would authorize a level annual appropriation from general revenues to the trust funds, starting in fiscal year 1966, that would amortize both the accumulated backlog and the additional amounts that will accrue through fiscal year 2015. After 2015, annual appropriations would be authorized to pay any additional costs.

E. General Discussion of Public Assistance Amendments

1. INCREASED FEDERAL PAYMENTS UNDER PUBLIC ASSISTANCE TITLES

Your committee's bill provides for an increase in the payments to public assistance recipients, effective January 1, 1966. The formula determining the Federal share of assistance payments is liberalized by increasing the Federal proportion of the payments in the first step of the formula and by raising the ceiling on Federal sharing in the

second step of the formula. For the adult categories—OAA, APTD, AB, and for the combined program for the aged, blind, and disabled—the formula is changed from twenty-nine thirty-fifths of the first $35 of the average assistance payment to thirty-one thirty-sevenths of the first $37 of the average assistance payment. The ceiling is raised on the average payments from $70 a month to $75 a month. The provisions in the formula under titles I and XVI adding $15 to the ceiling for vendor medical care payments in which there can be Federal participation and otherwise recognizing medical payments are not affected by this formula change, except that the steps of the statutory formula are rearranged to improve their equitable application.

For the program of AFDC, the formula change made in your committee's bill would be from fourteen-seventeenths of the first $17 of the average payment per recipient to five-sixths of the first $18 of the average assistance payment. The ceiling is raised from $30 a month to $32 a month. Under your committee's bill, there would be an increase in Federal payments averaging about $2.50 a month for the needy recipients in the adult assistance categories and an increase of about $1.25 a month for the needy children and the adults caring for them. The level of aid provided the needy justifies this modest increase.

2. REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DISEASES

Since the enactment of the Social Security Act, patients in public mental and tuberculosis hospitals have not been eligible under the public assistance titles of the Social Security Act, and only prior to 1951 were individuals eligible who were patients in private mental and tuberculosis hospitals. The reason for this exclusion was that long-term care in such hospitals had generally been accepted as a responsibility of the States. In the opinion of your committee, contemporary developments in the treatment of mental disorders and tuberculosis justify a new approach to the problem of the care of the aged who have these diseases. A partial recognition of this change in the treatment of the mentally ill and the tuberculous was made in 1960, when this committee recommended and the Congress acted to permit Federal participation in the cost of medical payments for aged persons diagnosed as psychotic or tubercular when they are in general medical hospitals because of such diagnosis, for up to 42 days. Although this amendment has proved useful, your committee believes a more fundmental change in the Federal law is needed if new treatment methods are to be more widely used in the Nation.

There have been many encouraging developments in the care and treatment of the mentally ill and the tuberculous. Most significantly progress is being made in the provision of short-term therapy in the patient's own home, in special sections of general hospitals, in specialized mental hospitals, and in community mental health centers. This latter type of facility is being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963.

With the progress in development of short-term therapy for the mentally ill and the tuberculous, your committee believes that the distinction hitherto maintained in the public assistance titles of the Social Security Act—between the aged who are ill with a diagnosis of

psychosis or tuberculosis and the aged with other diagnosed illnesses is no longer necessary or desirable. Your committee is convinced that the entire mental health program of the States can be advanced and the care of the mentally ill aged can be materially improved by the elimination of the distinction in the Federal law between disease classifications. Thus, under the provisions of your committee bill, Federal financial participation would become available effective January 1, 1966, in assistance (money payments, if appropriate, or payment for medical care) for aged persons otherwise eligible under State plans for OAA, MAA, or under the combined programs for the aged, blind or disabled who: (1) are patients in hospitals for mental diseases or for tuberculosis or (2) are patients in general hospitals without regard to the length of their stay, who are there because of a diagnosis of psychosis or tuberculosis. Federal financial participation would also become available for assistance under titles X, XIV, and XVI of the Social Security Act for blind or disabled persons of any age who are in a general hospital with a diagnosis of phychosis or tuberculosis.

Since the provisions of the bill are designed to improve the care provided by States and to assure that Federal participation is used for such improvement, it is not intended that the availability of care for the mentally ill or tubercular under other State or local programs be considered a resource in determining the eligibility of patients for public assistance with Federal participation in the payments made.

Your committee is concerned that certain safeguards and standards are maintained. These safeguards are to be included in the plans of States which wish to take advantage of these provisions for the provision of assistance to or in behalf of patients in mental or tuberculosis hospitals. Your committee believes that the closest collaboration in the planning and execution of the plans will be needed by the State welfare agencies and the State agencies responsible for the programs for the mentally ill and the tuberculous. Your committee's bill is intended to broaden the resources available to the community (including the public welfare agencies) in planning for the needy aged who have these diseases. For this reason, your committee has included in its bill a provision for a joint agreement or other arrangement between the units of State or (where appropriate) local governments, and where appropriate with institutions for mental diseases or tuberculosis. This agreement is not only intended to set forth the way of work between the agencies administering welfare and health programs, but also to set forth alternative methods of care, particularly for the aged who are mentally ill. Institutional treatment and care in the individual's own home are only two of the possible ways of caring for the aged who have mental problems. It is expected that the joint agreements will include plans for the use of other methods of care, such as nursing homes, short-term care in general hospitals, foster family care, and others. This legislation, it is anticipated, will give further encouragement to the trend in the States for discharging from mental hospitals to the community the aged who are considered able to care for themselves, under some form of protective arrangements. Your committee is aware that not always does a discharge plan work out to the best advantage of the patient, and thus your committee's bill provides that the agreement must make provision for the prompt readmittance to the institution where needed for

the aged person who had been placed under alternate plans of care. Inasmuch as the public welfare agency will be responsible for the determination of eligibility under the State plan for all applicants for assistance in the hospital, it is important that representatives of the agency have free access to the patient in the hospital. It is equally important that the hospital give to the public welfare agency the information it needs to administer its part of the program including the provision of assistance and the related social services. Under your committee bill, the agreement must include these arrangements.

A second safeguard, under your committee's bill, is a provision that the State plan include a provision for an individual plan for each patient in the hospital to assure that the care provided to him is in his best interests and that there will be initial and periodic review of his medical and other needs. Your committee is particularly concerned that the patient receive care and treatment designed to meet his particular needs. Thus, under your committee bill, the State plan would also need to assure that the medical care needed by the patient will be provided him and that other needs considered essential will be met and that there will be periodic redetermination of the need for the individual to be in the hospital.

Your committee bill provides for the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals. This is intended to include provision for persons who no longer need care in hospitals and who can, with financial help and social services to the extent needed, make their way in the community. Under the 1962 public welfare amendments, State public welfare agencies are encouraged to provide social services for the aged and additional Federal financing is available to assist in the cost. Under your committee bill, these social services would be made available, as appropriate, for the aged who are in the hospitals or who would otherwise need care in an institution.

Your committee believes that responsibility for the treatment of persons in mental hospitals—whether or not they be assistance recipients—is that of the mental health agency of the State. Social services may be needed for members of the patient's family, and this responsibility can be carried by the local welfare agency with Federal financial help. When the patient leaves the mental hospital to receive one of the alternative methods of care, followup social services are usually essential if the discharge plan is to be successful. Such services can be given by the public welfare agency or (if provided in the agreement between the two agencies referred to earlier) could be given by the staff of the hospital. Social services to the aged who have mental health problems, your committee believes, are important as a means of preventing further deterioration and avoiding or delaying admittance or readmittance to the institution.

Your committee recognizes that the administration of these provisions will place new responsibilities upon the welfare agencies and if these responsibilities are to be carried out effectively, appropriate planning and execution will be required. Thus your committee's bill provides authority for the Secretary to establish necessary methods of administration for the States in carrying out these provisions.

Under the bill, the Federal Government will be participating in the costs of care given to the needy aged in certain institutions. In

order to assure that the rates for the care of recipients who are patients in such institutions are reasonable, the bill provides that the State must have suitable methods for the determination of the cost. Your committee expects that this determination will be made without imposing burdensome fiscal methods on the States.

Your committee believes it is important that States move ahead promptly to develop comprehensive mental health plans as contemplated in the Community Mental Health Centers Act of 1963. In order to make certain that the planning required by your committee's bill will become a part of the overall State mental health planning under the Community Mental Health Centers Act of 1963, your committee's bill makes the approvability of a State's plan for assistance for individuals in mental and tuberculosis hospitals dependent upon a showing of satisfactory progress toward developing and implementing a comprehensive mental health program—including utilization of community mental health centers, nursing homes, and other alternative forms of care.

Your committee wishes to insure that the additional Federal funds to be made available to the States under the provisions of the bill will assist the overall improvement of mental health services in the State. State and local funds now being used for institutional care of the aged will be released as a result of the bill, but there is great need for increased professional services in hospitals and for development of alternate methods of care outside the hospitals. To accomplish this, States may have to reallocate their expenditures for mental health to promote new methods of treatment and care. Your committee bill provides that the States will receive additional Federal funds only to the extent that a showing is made to the satisfaction of the Secretary that total expenditures of the States or its political subdivisions from their own funds for mental health services are increased. Such expenditures may be financed under State or local public health or public welfare programs. Expenditures will be measured against a base period and will include comparable items of expenditure for mental health programs by State and local public health and welfare agencies, including expenditures for payments to or in behalf of public assistance recipients with mental health problems and expenditures for services and other administrative items under health and welfare programs.

3. PROTECTIVE PAYMENTS

Your committee has been concerned about the problems of our aged citizens who have marginal capacity to handle their own affairs. Old-age assistance recipients are among those with the most serious problems, both because of their advanced age (average age is 76) and because they have so little resources that the usual guardianship services under State law may not be available. States may now, with Federal participation, use guardians as payees for public assistance payments, or under section 1111 of the Social Security Act, enacted in 1958, may use a special legal representative as the payee. Your committee has been advised that these arrangements still do not offer enough flexibility to meet all the needs that arise and thus, the bill contains additional provisions.

Under your committee's bill, States with Federal financial participation may make a protective payment to a third party, someone with

an interest or concern for the individual recipient. This provision is similar to the protective payment provision included in the AFDC program as one part of the 1962 Public Welfare Amendments. It would be effective January 1, 1966, and would be applicable to recipients of money payments under title I or title XVI.

Your committee is aware of the serious nature of a decision not to give a needy person the money which he would ordinarily receive directly, but instead to pay it in his behalf to a third party. Your committee's bill, therefore, has several safeguards to protect the individual's rights. For Federal sharing to be claimed in such payments, the State plan, under the bill, would have to show that a determination will be made that such individual has, by reason of his physical or mental condition, such inability to manage his own money that making payments directly to him would not be in his best interests. Furthermore, States would be able to make payments with Federal sharing only when the payments meet all the need, as determined under the State plan, of the individual. This safeguard was included by your committee because some States do not meet need according to their own standards and thus it is possible that the difficulty ascribed to the individual in handling his money may be due to the inadequate assistance he is receiving.

The State plan would have to show, in addition, that the State is undertaking and continuing efforts to protect the welfare of the individual and to the extent possible, improve his capacity for self-care and to handle his money. To avoid the possibility of protective payment arrangements continuing beyond the period necessary, the bill provides, further, that the State agency will need to make periodic reviews to determine whether conditions justify the continuation of the arrangement and if they do not, for direct payments to be resumed, or if the conditions warrant, for the judicial appointment of a guardian or a legal representative as authorized by section 1111 of the Social Security Act. The bill also provides specifically that the State agency must offer to the individual affected, if he is dissatisfied, an opportunity for a fair hearing on the decision to make his payment to a third party.

4. DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED UNDER OLD-AGE ASSISTANCE AND COMBNED PROGRAMS

Your committee's bill provides for a modest increase in the amount of earnings States may disregard in determining need under the program of OAA and for the aged receiving assistance under the combined program for the aged, blind, and disabled. Currently, States may disregard no more than the first $10 a month, and one-half of the remainder within a total of $50 per month of earned income. The bill would raise those amounts to $20 a month and one-half of the remainder within a total of $80 per month of earned income, effective January 1, 1966.

Your committee is convinced that it is sound for the aged to continue in employment as long as they can, and that those who work should have some incentive and special consideration. Currently 23 States have implemented the earlier legislation and are disregarding some earned income of the aged. This amendment will permit these

States, and others which have not yet acted, to implement the legislation to increase the amounts disregarded.

5. ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN ADMINISTRATIVE DETERMINATIONS

Your committee bill contains new provisions effective January 1, 1966 for administrative and judicial review of certain administrative determinations under titles I, IV, X, XIV, XVI, and XIX of the Social Security Act. These provisions are designed to assure that the States will not encounter undue delays in obtaining Federal determinations on acceptability of proposed State plan material under the public assistance programs, and that the States will be able to obtain judicial review of their plan proposals at an appropriate stage of the proceedings. These provisions are not intended to affect adversely the usual negotiation process between the Department of Health, Education, and Welfare and the States which, in nearly all instances, results in the development of a State plan or plan amendment that can be approved by the Secretary.

When a State submits a new plan under one of the public assistance titles, the Secretary shall make a determination within 90 days as to whether the proposal meets the applicable requirements for approval. This period may be extended by written agreement of the Secretary and the State. If the State is dissatisfied with the Secretary's determination, it may, within 60 days, petition for a reconsideration. The Secretary shall then set a time and place for a hearing, to begin from 20 to 60 days after the date notice of the hearing is furnished to the State, unless the Secretary and the State agree in writing upon another time. Within 60 days of the conclusion of the hearing, the Secretary shall affirm, modify, or reverse his original determinations. If the State is dissatisfied with this final determination, it may, within 60 days, appeal to the U.S. court of appeals. In the judicial proceeding, the findings of fact by the Secretary shall be conclusive, unless substantially contrary to the weight of the evidence; if good cause is shown for taking further evidence, the court may remand the case to the Secretary for this purpose. The court may affirm the action of the Secretary or set it aside, in whole or in part. The court's judgment shall be subject to review by the Supreme Court of the United States upon certiorari or certification.

The foregoing procedures are also applicable, at the option of the State, upon submittal of any amendment of an approved State plan.

The bill does not amend sections 4, 404, 1004, 1404, 1604, or 1904 of the Social Security Act, which provide that the Secretary shall give reasonable notice and opportunity for hearing to a State prior to discontinuing payments under a previously approved State plan because of his finding that the plan has been so changed that it no longer complies with certain requirements or that in the administration of the plan there is a failure to comply substantially with certain requirements. However, the bill provides that upon any such final determination by the Secretary, the State may appeal to the U.S. court of appeals, in the same way as described above for appeals from a final determination of the Secretary in connection with submittal of a new plan.

The bill further provides that action pursuant to an initial deter-

mination of the Secretary, as therein described, shall not be stayed pending reconsideration. If the Secretary subsequently determines that his initial determination was incorrect, he shall pay forthwith in a lump sum any amounts, not otherwise already paid, which are payable to the State in accordance with the corrected determination of the Secretary on the basis of the expenditures made by the State.

In addition to questions concerning State plan proposals, or which involve discontinuance of Federal payments under part or all of a State plan, disagreements between a State and the Secretary may occur when the Secretary disallows specific State expenditures for Federal financial participation. Such disallowances usually take the form of audit exceptions. The bill provides that whenever the Secretary determines that there shall be a disallowance the State shall be entitled, on request, to an administrative reconsideration of the decision.

6. MAINTENANCE OF STATE EFFORT

Under various provisions of this bill, additional Federal funds will be available to States to improve the public assistance program. Your committee has recognized the need for such program improvement in medical care, in basic maintenance, as well as in other areas, and believes that the Federal funds designated for these purposes should be used by the States for these purposes and not as a substitute for State funds. For this reason, the bill incorporates a provision which assures that the additional Federal funds made available to States are used within the public assistance program. Additional Federal funds will, under these provisions, be granted to States only to the extent that existing State expenditures in the program are maintained. For a period beginning January 1, 1966, and ending June 30, 1969, a measurement of these expenditures will be made in the process of granting the Federal funds to the States. Your committee believes that after June 30, 1969, the new funds will be so integrated into the programs of the States that further testing of this fact will not be needed.

Under the bill, expenditures from total and Federal funds for a particular quarter are compared with total and Federal expenditures in a "base period," either the corresponding quarter or an average of the quarters in the fiscal year ending June 30, 1964, or June 30, 1965. If this comparison shows that the increase in Federal funds as computed under the revised formula exceeds the increase in total expenditures, the increase in Federal share must be reduced to the amount of the increase in total expenditures between the base period and the quarter in question. The purpose of this provision is to assure that whatever additional Federal funds are made available to the States

under the revised formulas for computing the Federal share and under provisions for program expansion will be used for program improvements and that no part of any additional Federal funds will be used to replace non-Federal funds.

7. DISREGARDNING SO MUCH OF OASDI BENEFIT INCREASE AS IS ATTRIBUTABLE TO RETROACTIVE EFFECTIVE DATE

Under title III of the bill, beneficiaries of the OASDI program will receive a 7-percent increase in their benefits retroactively effective to January 1, 1965. These benefits will be payable to beneficiaries in a lump-sum check in addition to the regular monthly check. There are currently many thousands of such beneficiaries who are receiving supplementary assistance from various of the public assistance programs under provisions of the Social Security Act. Moreover, certain children over 18 and in school will receive benefits from January 1, 1965. Your committee believes that it would be appropriate for the State public assistance agencies to disregard these retroactive payments as one-time-only income, not significant in amount and not income which under various other longstanding provisions of the public assistance titles to the act must be taken into account by the State in determining the amount of assistance for the individual.

The bill adds a provision to make it clear that States need not take these sums into consideration in determining the need of the public assistance recipients who also receive an OASDI benefit.

8. AMENDMENT TO DEFINITION OF MEDICAL ASSISTANCE FOR THE AGED

When the MAA program was enacted in 1960, the law prohibited Federal sharing in MAA payments made in behalf of an aged person receiving OAA in the month MAA services were received. This provision has proved to be a hardship in the planning of States for the necessary movement of ill aged persons to and from medical institutions such as nursing homes and hospitals. For the month of movement to or from such a medical facility, States are faced with a heavy expenditure of funds, only part of which, under current provisions of law, is subject to Federal sharing. A State which has made an OAA payment to a needy person to cover his expenses in his own home is unable to claim any Federal funds as MAA when the individual goes to a medical institution that month. The reverse situation arises when the individual leaves the medical institution in which services are received under MAA.

In order to meet this need, the bill would relax the prohibition on Federal sharing in OAA and MAA for the same month so as to permit such sharing effective July 1, 1965, for MAA services furnished in the month an individual enters or leaves a medical facility.

9. EXTENSION OF GRACE PERIOD FOR DISREGARDING CERTAIN INCOM FOR STATES WHERE LEGISLATURE HAS NOT MET IN REGULAR SESSION

Section 701 of the Economic Opportunity Act of 1964 provides that certain amounts of income of an individual derived from titles I and II of that act may not be taken into account by State public assistance agencies in determining the need of such individual or any other individual for public assistance under programs authorized by the Social Security Act. The purpose of this amendment was to provide an incentive for persons who are beneficiaries of programs under the Economic Opportunity Act to undertake training and employment by permitting public assistance payments to continue for them and their families, if they are otherwise eligible, and not be reduced by specified amounts of their income under such programs. The statute provides that States with a legislative impediment to putting this provision into effect shall have until July 1, 1965, to obtain the necessary legislative change. A problem has arisen in the instance of States which do not have a regular meeting of their legislature until 1966 to make the necessary changes to State law. Under this section of the bill, such States would have until the first month following the month of adjournment of a State's first regular legislative session adjourning after the date of enactment of the Economic Opportunity Act of 1964 to act.

10. TECHNICAL AMENDMENTS TO ELIMINATE PUBLIC ASSISTANCE PROVISIONS WHICH BECOME OBSOLETE IN 1967

Title XIX, to be added to the Social Security Act by title I of this bill, would, effective July 1, 1967, provide the sole statutory base for States to receive Federal funds for the provision of payments for vendor medical care in behalf of the needy. On that date, Federal financial participation in vendor payments for medical care will not be possible under other of the public assistance titles of the act. Thus, on July 1, 1967, numerous provisions of the various public assistance titles become inoperative. The bill identifies those provisions and appropriately repeals or amends them as of July 1, 1967.

11. COSTS OF INCREASES IN THE PUBLIC ASSISTANCE MATCHING FORMULAS

The accompanying table shows by State and by assistance programs the additional amounts of money that will be available to States under the changes in public assistance formulas made by title IV. These total almost $150 million for the first full year, or $75 million for the 6 months of the fiscal year ending June 30, 1966, that they would be effective. Like other increases in public assistance provided by the bill, the States would receive these amounts only to the extent that they made corresponding increases in their total expenditures.

Public assistance: Estimated annual increase in Federal funds under proposal to raise Federal participation in assistance payments to specified levels [1]

[In thousands]

States and District of Columbia	Total all programs	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to the aged, blind, and disabled (title XVI)	Aid to families with dependent children
Total	$148,520	$50,953	$2,352	$10,194	$22,117	$62,904
Alabama	3,817	2,640	42	346	----------	789
Alaska	154	(2)	(2)	(2)	69	85
Arizona	933	319	38	68	----------	508
Arkansas	2,012	1,392	47	221	----------	352
California	22,919	11,495	523	2,008	----------	8,893
Colorado	2,731	[3] 1,735	11	253	----------	732
Connecticut	1,543	321	13	172	----------	1,037
Delaware	203	32	13	18	----------	140
District of Columbia	581	100	8	130	----------	343
Florida	3,354	(2)	(2)	(2)	2,167	1,187
Georgia	3,691	2,206	76	624	----------	785
Hawaii	344	(2)	(2)	(2)	97	247
Idaho	494	220	6	67	----------	201
Illinois	8,543	(2)	(2)	(2)	3,751	4,792
Indiana	1,260	557	76	45	----------	582
Iowa	2,172	1,286	54	50	----------	782
Kansas	1,829	(2)	(2)	(2)	1,201	628
Kentucky	2,620	(2)	(2)	(2)	1,682	938
Louisiana	4,992	3,186	134	452	----------	1,220
Maine	568	(2)	(2)	(2)	329	239
Maryland	1,791	(2)	(2)	(2)	519	1,272
Massachusetts	4,497	2,295	96	494	----------	1,612
Michigan	5,308	(2)	(2)	(2)	2,481	2,827
Minnesota	2,008	[3] 988	48	82	----------	890
Mississippi	2,874	1,782	71	415	----------	606
Missouri	4,288	2,489	164	351	----------	1,284
Montana	456	249	11	58	----------	138
Nebraska	968	553	29	108	----------	278
Nevada	199	107	7	[4]	----------	85
New Hampshire	315	196	12	25	----------	82
New Jersey	2,510	335	40	349	----------	1,786
New Mexico	950	(2)	(2)	(2)	331	619
New York	12,844	(2)	(2)	(2)	3,977	8,867
North Carolina	3,099	1,047	122	523	----------	1,407
North Dakota	476	(2)	(2)	(2)	330	146
Ohio	6,860	2,873	141	786	----------	3,060
Oklahoma	6,115	(2)	(2)	(2)	4,650	1,465
Oregon	1,036	269	18	187	----------	562
Pennsylvania	6,484	1,937	216	471	----------	3,860
Rhode Island	802	(2)	(2)	(2)	374	428
South Carolina	1,228	629	43	205	----------	351
South Dakota	404	174	3	26	----------	201
Tennessee	2,373	1,099	53	301	----------	920
Texas	6,899	5,504	116	221	----------	1,058
Utah	647	122	8	114	----------	403
Vermont	224	(2)	(2)	(2)	159	65
Virginia	1,058	322	28	161	----------	547
Washington	2,540	812	28	437	----------	1,263
West Virginia	1,978	352	20	148	----------	1,458
Wisconsin	2,375	1,266	35	252	----------	822
Wyoming	154	64	2	26	----------	62

[1] For OAA, AB, APTD, and AABD (title XVI), raise 29/35 of $35 to 31/37 of $37; and for AFDC, from 14/17 of $17 to 5/6 of $18; raise maximum average monthly payment from $70 to $75; and for AFDC, from $30 to $32. Assumes that States will continue to spend the same amount per recipient from State and local funds as in May 1964, and that the increase in Federal funds will be used to raise money payments to recipients.

[2] Combined under aid to the aged, blind, and disabled.

[3] Based on State's estimate of the number of recipients and average payment for September 1964, which shows transfers from OAA to MAA, not reflected in May data.

[4] No program for APTD.

Summary—Cost of public assistance and related items

[In millions of dollars]

Costs	Fiscal year 1965	Annual rate
Title I, pt. 2: Medical assistance	100	200
Title II:		
Pt. 1: Maternal and child health, crippled children	25	60
Pt. 2: Mental retardation projects	2.75	2.75
Pt. 3: Mental and tuberculosis	38	75
Pt. 3: Medical assistance for the aged definition	2	2
Title IV:		
Formula changes	75	150
Protective payments	(1)	(1)
Income exemption (old-age assistance)	.5	1
Total	243.25	490.75

[1] No cost.

F. Medical Expense Deductions for Income Tax Purposes

1. PRESENT LAW

As a general rule under the Internal Revenue Code only that portion of the medical care expenses paid by the taxpayer for himself, his spouse, or his dependents which exceeds 3 percent of adjusted gross income may be deducted. Included in the category of deductible medical expenses subject to this 3-percent floor are premiums paid for accident and health insurance. In computing medical care expenses for the purpose of applying the 3-percent limitation, expenses for medicines and drugs are included only to the extent that they exceed 1 percent of adjusted gross income. An exception is presently made to these general rules, however, in the case of medical care expenses incurred by a taxpayer or his spouse if either is 65 or over, or for his dependent mother or father (or mother-in-law or father-in-law) if 65 years of age or more. The expenses for medical care of such persons may be deducted without regard to either the 3-percent or the 1-percent limitations.

Under present law, certain maximum limitations are also imposed with respect to medical expense deductions. With the exception of disabled persons, these maximum limitations do not vary according to age. Generally, the maximum medical expense deduction which may be taken is $5,000 multiplied by the number of exemptions claimed (other than those for age or blindness), not to exceed $10,000 in the case of a single taxpayer or $20,000 in the case of a married couple (or head of household or surviving spouse). In the case of disabled taxpayers and their spouses, however, who have attained the age of 65, the maximum $10,000 or $20,000 limitation referred to above is increased to $20,000 or $40,000, respectively.

2. GENERAL REASONS FOR PROVISION

The health care provisions of your committee's bill have a relationship to the medical expense deductions allowed under the Internal Revenue Code. The 3-percent limitation in the case of medical care expenses and the 1-percent limitation applied to expenditures for medicines and drugs were waived for persons 65 or over in recognition of the fact that medical expenses generally constituted

a heavy financial burden for older people. The limitations were waived, however, during a period when there was no broad-coverage health insurance plan for older persons. The insurance provisions of your committee's bill are designed to meet these problems. The reasons for the special medical expense provisions in the tax law for the relief of older taxpayers, therefore, no longer appear to exist.

Moreover, restoration of a uniform floor to be applied in the computation of the medical expense deduction will provide an increase in revenue which will help defray to some degree the cost of the general fund of the voluntary insurance provisions in your committee's bill. Only in the case of an older person with sufficient income to be taxable will the benefit of the Federal Government's $36-per-year contribution towards his voluntary medical insurance coverage be reduced or offset by a lesser deduction for medical care expenses.

Restoration of a uniform medical expense deduction rule also will serve to simplify the tax law. Present law necessitates a careful distinction between the medical care expenses of persons 65 or over and the similar expenses of persons under 65. A complex special form is employed for this purpose. The need for this special form will be eliminated by the establishment of a single uniform rule for those over and under age 65.

The bill also permits, for all persons regardless of age, the deduction of a portion of medical insurance premiums without regard to the 3-percent limitation in recognition of the fact that existing law may have the effect of discouraging the provision of insurance protection against future medical bills. Under present law medical insurance premiums may not be deductible because provision for medical expenses by insurance tends to even out these charges over a period of years and, therefore, makes it more likely that in any specific year the 3-percent limitation will not be exceeded. Medical expenses of those not covered by insurance tend to vary more from year to year and thus in some years are more likely to exceed the 3-percent limitation and be deductible.

3. GENERAL EXPLANATION

Your committee's bill (sec. 106), therefore, amends the Internal Revenue Code (sec. 213) to terminate present special treatment of the medical care expenses of taxpayers who are 65 or over. Thus, the provision of present law limiting medical expense deductions for a taxpayer, his spouse, or his dependents where they are under age 65 to the amount of such expenses in excess of 3 percent of adjusted gross income is extended to all taxpayers, spouses, and dependents regardless of age. This is also true of the provision under present law limiting expenditures for medicines and drugs which are taken into account for purposes of the 3-percent limitation to the amount in excess of 1 percent of adjusted gross income. These limitations, therefore, will, in the future, apply to taxpayers and their spouses who have attained age 65 as well as dependent mothers or fathers of the taxpayer (or of his spouse) who have attained the age of 65.

The bill also removes the distinction in the maximum medical expense deduction allowance between disabled taxpayers over and under age 65. This is accomplished by extending the $20,000 maximum deduction presently available to single taxpayers and the $40,000 ceiling

available to married taxpayers filing joint returns to disabled taxpayers under age 65.

The bill further provides that all taxpayers itemizing their deductions, regardless of age, are to be granted a deduction, without regard to the 3-percent floor, for one-half the cost of medical care insurance for the taxpayer, his spouse, and his dependents, but not to exceed $250. The other half of any premiums paid, plus any excess over the $250 limit for medical care insurance, will continue to be subject to the 3-percent floor and only when they plus any other allowable medical expenses exceed 3 percent of adjusted gross income will they be deductible. Included in the category of medical insurance premiums which may be deducted (one-half under, and one-half apart from, the 3-percent floor) are those for supplementary health insurance benefits for the aged but not the taxes transferred to the trust fund for hospital insurance benefits for the aged.

The bill also makes certain other amendments to the medical expense deduction provisions of the Internal Revenue Code. The definition of medical care is revised to specifically limit the deductible portion of premiums paid on multipurpose health and accident policies to the actual cost of providing insurance protection against medical care expenses, as defined in the Internal Revenue Code. The cost of insurance allocable to income continuation payments when illness or accident causes absence from work and the cost of insurance which provides indemnity in the case of the loss of a limb, etc., is not to be deductible. This revision becomes particularly important in view of the provision which permits the deduction of one-half of the premiums paid for medical care insurance without regard to the 3-percent limitation.

The bill qualifies as a current medical expense certain premiums paid during the taxable year by a taxpayer under the age of 65 for insurance for the medical care expenses of the taxpayer, his spouse, and his dependents which will be incurred after the taxpayer attains the age of 65. However, these payments, to qualify as a current expense, must be made under a contract which provides for level premium payments over a specified minimum period. This provision, which applies only to insurance for medical care expenses, is designed to remove any impediment which might otherwise exist to the voluntary provision by a person under 65 of medical care protection for his post-65 years. This is not intended, however, to foreclose the allowance of any presently available deduction for other prepayments.

4. EFFECTIVE DATE

These provisions apply to medical care expenses incurred in tax years beginning after December 31, 1966. The provisions will, therefore, not become effective until the health care provisions of the bill have been in operation for 6 months.

5. REVENUE EFFECT

The provision reinstituting the deduction floors is expected to increase revenues by $170 million but it is expected that the deduction of one-half the cost of medical insurance premiums without regard to the 3-percent limitation will decrease revenues by $88 million. Overall, it is estimated that the provisions will increase revenues by $82 million in a full year of operation. This, of course, is much more than offset by health care payments made from the general fund of the Treasury. The distribution of this total by specific provisions and adjusted gross income classes is shown below.

Distribution of tax revenue estimates under revised medical expense deduction

[In millions of dollars]

Adjusted gross income	[1] Application of 3-percent and 1-percent limitations to all taxpayers [2]	Increased medical expense deduction [3]
0 to $3,000	1	−9
$3,000 to $5,000	9	−3
$5,000 to $10,000	20	−31
$10,000 to $20,000	24	−32
$20,000 to $50 000	47	−10
$50,000 and over	69	−3
Total	170	−88

[1] This additional revenue will be derived from those age 65 and over.

[2] Assumes a reduction in hospitalization and medical expenses of 50 percent for taxpayers with incomes under $10,000 and 25 percent for those with incomes over $10,000.

[3] Includes effect of allowing a deduction of ½ cost of all medical insurance premiums without regard to the 3-percent limitation and effect of medical expense deductions for premiums paid for voluntary insurance coverage under this bill. This reduction goes to taxpayers of all age groups.

IV. SECTION-BY-SECTION ANALYSIS OF THE BILL

The first section contains the short title of the bill—the "Social Security Amendments of 1965"—and a table of contents. The remainder of the bill is divided into four titles, and titles I and II into several parts, as follows:

Title I—Health Insurance For the Aged and Medical Assistance
- Part 1—Health Insurance Benefits for the Aged
- Part 2—Grants to States for Medical Assistance Programs

Title II—Other Amendments Relating to Health Care
- Part 1—Maternal and Child Health and Crippled Children's Services
- Part 2—Implementation of Mental Retardation Planning
- Part 3—Public Assistance Amendments Relating to Health Care

Title III—Social Security Amendments

Title IV—Public Assistance Amendments

TITLE I—HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE

Section 100 of the bill provides that title I of the bill may be cited as the "Health Insurance for the Aged Act."

Part 1—Health Insurance Benefits for the Aged

SECTION 101. ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Section 101 of the bill adds at the end of title II of the Social Security Act a new section 226, dealing with entitlement to hospital insurance benefits (i.e., entitlement to have payment of benefits made under part A of the new title XVIII of the Social Security Act (as added by section 102 of the bill)).

Section 226(a) provides that any individual who has attained the age of 65, and who is entitled to monthly old-age and survivors insurance benefits or is a "qualified railroad retirement beneficiary", is entitled to hospital insurance benefits under part A of the new title XVIII for each month (including, if applicable, any month of retroactive entitlement to monthly OASI benefits as provided in section 202(j)(1) of the Social Security Act and any month of retroactive entitlement to benefits as provided in section 21 of the Railroad Retirement Act of 1937) in which he meets such conditions, beginning with July 1966.

Paragraph (1) of section 226(b) provides that entitlement of an individual to hospital insurance benefits consists of entitlement to have payment made on his behalf for inpatient hospital services,

post-hospital extended care services, post-hospital home health services, and outpatient hospital diagnostic services furnished him in the United States. It also provides that no payment for post-hospital extended care services may be made for services furnished before January 1967 and that payment for post-hospital extended care services or post-hospital home health services may be made only if the discharge from a hospital required to permit payment with respect to such services occurs after June 30, 1966, or on or after the first day of the month in which the individual attains age 65, whichever is later.

Paragraph (2) of section 226(b) provides that an individual entitled under section 226 is entitled to hospital insurance benefits for the month in which he dies.

Section 226(c) provides that the term "qualified railroad retirement beneficiary" means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 21 of the Railroad Retirement Act of 1937 (as added by section 105 of the bill), and that an individual will cease to be a qualified railroad retirement beneficiary at the close of the month before the month which is certified by the Board as the month in which he ceased to meet the requirements of such section 21.

Section 226(d) contains a cross-reference to section 103 of the bill which provides entitlement to hospital insurance benefits for certain individuals not eligible for benefits under section 226.

SECTION 102. HOSPITAL INSURANCE BENEFITS AND SUPPLEMENTARY HEALTH INSURANCE BENEFITS

Section 102(a) of the bill amends the Social Security Act by adding after title XVII a new title XVIII providing health insurance for the aged and consisting of part A (hospital insurance for the aged), part B (supplementary health insurance benefits for the aged), and part C (miscellaneous provisions).

Title XVIII—Health Insurance for the Aged

SECTION 1801. PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

Section 1801 states that nothing in the new title XVIII is to be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine, the manner in which medical services are provided, the personnel policies of providers of health care, or the operation or administration of medical facilities and personnel.

SECTION 1802. FREE CHOICE BY PATIENT GUARANTEED

Section 1802 provides that any individual entitled to benefits under title XVIII may obtain health services from any institution, agency, or person which is qualified to participate under the title and which undertakes to provide the services to him.

SECTION 1803. OPTION TO INDIVIDUALS TO OBTAIN OTHER HEALTH INSURANCE PROTECTION

Section 1803 provides that nothing in title XVIII is to be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against health costs.

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED

SECTION 1811. DESCRIPTION OF PROGRAM

Section 1811 describes the insurance program for which entitlement is established under section 226 of the Social Security Act as one which provides basic protection against the costs of hospital and related post-hospital services for individuals age 65 or over who are entitled to retirement benefits under title II of the Social Security Act or under the railroad retirement system.

SECTION 1812. SCOPE OF BENEFITS

Section 1812(a) provides that the benefits provided to an individual under part A of the new title XVIII consist of entitlement to have payment made on his behalf for:

(1) inpatient hospital services (including such services in a tuberculosis hospital) for up to 60 days during any spell of illness;

(2) post-hospital extended care services for up to 20 days (or up to 100 days in the circumstances described in section 1812(c)) during any spell of illness;

(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next; and

(4) outpatient hospital diagnostic services.

Section 1812(b) provides that (subject to section 1812 (c) and (d), discussed below) payment may not be made for inpatient hospital services furnished to an individual in any spell of illness after such services have been furnished to him for 60 days during the spell or for post-hospital extended care services in any spell of illness after such care has been furnished to him for 20 days during the spell.

Section 1812(c) provides that, at the individual's option, the number of days for which payment for post-hospital extended care services may be made can be increased beyond 20 (but by no more than 80 days, for a maximum of 100) by twice the number by which the days for which the individual has already been furnished inpatient hospital service in the same spell of illness are less than 60. The number of days of inpatient hospital care for which payments could be made during the same spell of illness would be reduced by one day for each full two days of extended care above 20 for which payment is made (and by an additional day if the number of days of extended care is an odd number). The individual may conserve his inpatient hospital coverage by terminating the application of section 1812(c) at any time.

To illustrate the effect of section 1812(c), if an individual transferred to an extended care facility after a 10-day hospital stay and needed 63 days of extended care facility services, payment would be made

for the entire stay in the facility, including the 43 days beyond the initial 20, unless he elects to have payment cut off for some or all of the 43 days. If payment is made for the entire period of extended care he would, after discharge from the facility, remain eligible for 28 additional days of hospital care if he should need to be hospitalized again during the same spell of illness. That is, of the 60 days of hospital benefits, he would have received 10 days of benefits in the hospital, and he would have exchanged 22 days of hospital benefits for the 43 additional days of extended care benefits, leaving him with a balance of 28 days of hospital care. However, if the individual had requested that his days in the extended care facility beyond 20 not be paid for, he would have retained a balance of 50 days of hospital care.

Section 1812(d) provides that if an individual is an inpatient of a tuberculosis hospital on the first day of the first month for which he is entitled to benefits under part A, the days on which he was an inpatient of such a hospital in the 60-day period immediately before such first day will be included in determining the 60-day limit on inpatient hospital services insofar as it applies to him.

Section 1812(e) provides that payment may be made under part A for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section. Only the first 100 visits in the one-year period can be paid for. The number of visits to be charged in connection with the provision of covered home health items or services for this purpose is to be determined in accordance with regulations.

Section 1812(f) provides that inpatient hospital services, post-hospital extended care services, and post-hospital home health services will be taken into account for purposes of the limits on duration of coverage prescribed in the preceding subsections of section 1812 only if payment under part A is made or would be made with respect to such services if they had been furnished within such limits and if the request and certification requirements described in section 1814(a) had been met for such services.

Section 1812(g) contains a cross reference to the definitions of the terms used in part A which are found in section 1861.

SECTION 1813. DEDUCTIBLES

Paragraph (1) section 1813(a) provides that payment for inpatient hospital services furnished during any spell of illness will be reduced by the inpatient hospital deductible (the amount of which is determined under section 1813(b)). However, charges for a diagnostic study, up to the amount of the deductible which applies to a diagnostic study (described in paragraph (2)), by the same hospital during the 20-day period before the individual is admitted as an inpatient to the hospital, would be applied toward the inpatient hospital deductible.

To illustrate: An individual obtains diagnostic laboratory services in a hospital outpatient department on August 1, 1966, and is charged $15 for these services. On August 15 he is admitted as an inpatient to the same hospital in which he received the diagnostic services. He is permitted to apply his payment for the diagnostic services toward the inpatient hospital deductible ($40 in 1966); thus he would have to pay an inpatient hospital deductible of $25.

Paragraph (2) of section 1813(a) provides for a deductible with respect to outpatient hospital diagnostic services (furnished during a diagnostic study) equal to one-half the amount of the inpatient hospital deductible. A "diagnostic study" is defined as outpatient hospital diagnostic services provided by (or under arrangements made by) the same hospital during the 20-day period beginning on the first day (once he is entitled to benefits under section 226) on which outpatient hospital diagnostic services are furnished to him.

Paragraph (3) of section 1813(a) provides that payment cannot be made to any provider of services under part A for the cost of the first 3 pints of whole blood furnished to an individual during a spell of illness.

Paragraph (1) of section 1813(b) provides that the inpatient hospital deductible is $40 for any spell of illness (and is therefore $20 for any diagnostic study) beginning before 1969.

Paragraph (2) of section 1813(b) provides that the Secretary shall, between July 1 and October 1 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which is to be applicable in the case of any spell of illness or diagnostic study beginning during the succeeding calendar year. The inpatient hospital deductible will be equal to $40 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the preceding calendar year, to (B) the current average per diem rate for 1966. Any amount determined by the multiplication under this paragraph which is not a multiple of $5 will be rounded to the nearest multiple of $5 (or, if it is midway between two multiples of $5, to the next higher multiple of $5).

If, for example, the cost experience reviewed for purposes of the promulgation to be made in 1970 shows that the average per diem rate for inpatient hospital services during 1969 was $45.55 as compared to $39.80 in 1966, the amount of the deductible applicable in 1971 would be $45 ($40 multipled by $\frac{45.55}{39.80}$ and then rounded to the nearest multiple of $5).

The current average per diem rate for any year will be determined by the Secretary on the basis of the best information available to him as to the amounts paid under part A for inpatient hospital services plus the amounts which would have been paid but for the inpatient hospital deductible required under section 1813(a)(1).

SECTION 1814. CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of requests and certifications

Section 1814(a) provides that, except in the case of emergency hospital services (described in section 1814(d)), payment for covered services may be made only to providers of services which have an agreement with the Secretary entered into in accordance with section 1866 and only if the requirements of section 1814(a) with respect to requests and certifications are satisfied.

Paragraph (1) of section 1814(a) requires that a written request (signed by the individual who receives the services or by another

person when it is impracticable for him to do so) be filed for such payment under regulations to be issued by the Secretary.

Paragraph (2) of section 1814(a) requires that a physician certify (and recertify, in such cases and as often and with such supporting material as may be provided in regulations, but in any event before the 21st day in the case of inpatient hospital services received during a continuous period) that—

(A) in the case of inpatient hospital services (other than inpatient tuberculosis hospital services), the services were required to be given on an inpatient basis for medical treatment, or inpatient diagnostic study was medically required;

(B) in the case of inpatient tuberculosis hospital services, the services were required to be given on an inpatient basis by or under the supervision of a physician for the treatment of tuberculosis, and the treatment can be reasonably expected to improve the condition or render it noncommunicable;

(C) in the case of post-hospital extended care services, the services were required to be given on an inpatient basis because the individual needed skilled nursing care on a continuing basis for a condition for which he was hospitalized prior to transfer to the extended care facility, or which arose while receiving such care for such a condition;

(D) in the case of post-hospital home health services, the services were required because the individual was confined to his home (except when receiving services referred to in section 1861(m)(7)) and needed intermittent skilled nursing care, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would qualify as inpatient services if the institution met certain specified requirements) or post-hospital extended care services, and the services were furnished while the individual was under the care of a physician and under a plan established and reviewed periodically by a physician; or

(E) in the case of outpatient hospital diagnostic services, the services were required for diagnostic study.

Under the last sentence of section 1814(a), to the extent provided by regulations, the certification and recertification requirements of paragraph (2) would be deemed satisfied where a physician makes the certification or recertification at a date later than the day it was required under paragraph (2), if it is accompanied by such medical or other evidence as may be required by regulations.

Paragraph (3) of section 1814(a) provides that, in the case of inpatient tuberculosis hospital services, payment may be made only if the services are those which the records of the hospital indicate were furnished during periods when the individual was receiving treatment which could reasonably be expected to improve his condition or render it noncommunicable.

Paragraph (4) of section 1814(a) provides that payment may not be made for inpatient hospital services furnished an individual after the 20th day of a continuous stay or for post-hospital extended care services furnished continuously after a period of time prescribed in regulations if the Secretary, before such individual's admission to the hospital or extended care facility, has rendered an adverse decision under section 1866(d) after a finding that the hospital or extended

care facility is not making the necessary utilization reviews of long-stay cases.

Paragraph (5) of section 1814(a) provides that payment may not be made for inpatient hospital services or post-hospital extended care services furnished an individual during a continuous period after a finding (as described in section 1861(k)(4)) by the physician members of the appropriate utilization review committee that further inpatient hospital services or post-hospital extended care services are medically unnecessary. If such a finding has been made, payment may be made for services furnished through the 3rd day after the day the notice of such finding is received by the hospital or extended care facility.

Reasonable cost of services

Section 1814(b) provides that the amount to be paid any provider for services under part A is the reasonable cost of such services (subject to the deductibles under sec. 1813), as determined under section 1861(v) (discussed below).

No payments to Federal providers of services

Section 1814(c) provides that no payment is to be made to a Federal provider of services, except for emergency services, unless the Secretary determines that the provider is furnishing services to the public generally as a community institution or agency. Payment may not be made to any provider for any item or service which it is required to render at public expense under a law of or contract with the United States.

Payments for emergency hospital services

Section 1814(d) provides that payment may be made for emergency hospital services, in the absence of an agreement of the kind otherwise required between the Secretary and the hospital, to the extent that the Secretary would be required to make payment if the hospital had such an agreement in effect and otherwise meets the conditions of payment. (See section 1861(e) for the definition of a hospital eligible under this provision.) The hospital would have to agree, as a condition of payment under this provision, not to charge the patient for the emergency services.

Payment for inpatient hospital services prior to notification of non-eligibility

Section 1814(e) provides that if a hospital has acted reasonably and in good faith in assuming that an individual was entitled to have payment made for inpatient hospital services under part A, the hospital can receive payment for such services furnished to the individual, even though he is not entitled to have such payment made, prior to notification from the Secretary that the individual is not so entitled. However, this provision would apply only if such payment is precluded solely because the individual has used up his 60 days of entitlement to inpatient hospital services in the spell of illness; and no payment may be made unless the hospital refunds any payment already obtained from the individual or on his behalf with respect to the services involved. In any event, payment may not be made under this provision for services furnished an individual after the 6th elapsed day after the day of his admission to the hospital (not counting

Saturday, Sunday, or a legal holiday as an elapsed day). Payment to the hospital under section 1814(e) would constitute an overpayment to the individual (and could be recovered) under section 1870.

SECTION 1815. PAYMENT TO PROVIDERS OF SERVICES

Section 1815 provides that the Secretary will determine the amounts to be paid to providers of services under part A (such amounts to be paid not less often than monthly) from the Federal Hospital Insurance Trust Fund. The provider must furnish such information as the Secretary may request in order to determine the amounts to be paid to the provider.

SECTION 1816. USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

Section 1816(a) provides that if any group or association of providers of services wishes to have payments under part A made through a national, State, or other public or private agency or organization and nominates an agency or organization for this purpose, the Secretary may enter into an agreement with the agency or organization providing for the determination (subject to such review by the Secretary as may be provided for in the agreement) of the amounts to be paid under part A to such providers, and for the payment to such providers of the amounts so determined. The agreement could also include provision for the agency or organization to do all or any part of the following: (1) provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records and otherwise to qualify as participants in the program; and (2) serve as a center for communications between the providers covered under the agreement and the Secretary, make such audits of the records of such providers as may be necessary to assure proper payment, and perform such other functions as are necessary to carry out section 6181(a).

Section 1816(b) provides that the Secretary is not to enter into an agreement with an agency or organization under section 1816(a) unless he finds that (1) to do so is consistent with effective and efficient administration, (2) the agency or organization is willing and able to assist the providers in the application of safeguards against unnecessary utilization of services (and the agreement provides for such assistance), and (3) the agency or organization agrees to furnish to the Secretary such information acquired by it in carrying out its agreement as the Secretary may find necessary to perform his functions under part A.

Section 1816(c) provides that an agreement with an agency or organization under section 1816(a) may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the agency or organization for making payments to providers of services. Such an agreement will also provide for payment to the agency or organization of the necessary and proper costs of carrying out its functions performed or to be performed under the terms of the agreement.

Section 1816(d) provides that if the nomination of an agency or organization is made by a group or association of providers of services, it will not be binding on members of such group or association which

notify the Secretary of their election to that effect. Any provider may, upon notice, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination (and any provider which has not made a nomination) may elect to receive payments either directly from the Secretary or from any agency or organization which has entered into an agreement with the Secretary under section 1816(a) if the Secretary and such agency or organization agree to it.

Section 1816(e) provides that an agreement with the Secretary under section 1816(a) may be terminated by the agency or organization at such time and upon such notice as may be provided in regulations. An agreement may also be terminated by the Secretary at such time and upon such notice as may be provided in regulations, but only if he finds (after reasonable notice and opportunity for hearing) that the agency or organization has failed substantially to carry out the agreement or that the continuation of the agreement is disadvantageous or is inconsistent with the efficient administration of part A.

Section 1816(f) provides that an agreement with any agency or organization under section 1816(a) may require any of its officers or employees who are participating in carrying out the agreement to give surety bond to the United States in such amount as the Secretary may deem appropriate.

Paragraph (1) of section 1816(g) provides that no individual designated pursuant to such an agreement as a certifying officer will, in the absence of gross negligence or intent to defraud the United States, be liable for any payments incorrectly certified by him.

Paragraph (2) of section 1816(g) provides a similar immunity for disbursing officers who make an incorrect payment based upon a voucher signed by a certifying officer designated as provided in paragraph (1).

SECTION 1817. FEDERAL HOSPITAL INSURANCE TRUST FUND

Section 1817(a) creates the Federal Hospital Insurance Trust Fund, which will consist of amounts deposited in or appropriated to it as provided in part A. For the fiscal year ending June 30, 1966, and for each fiscal year thereafter, there are appropriated to the Trust Fund amounts equal to (1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 on wages reported to the Secretary of the Treasury after December 31, 1965, and (2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 on self-employment income reported to the Secretary of the Treasury on tax returns. These wages and self-employment income are to be certified by the Secretary of Health, Education, and Welfare on the basis of records established and maintained by him in accordance with such reports and returns. The amounts to be appropriated, which will be determined by the Secretary of the Treasury on the basis of estimates of the taxes, are to be transferred from time to time from the general fund of the Treasury to the Trust Fund, with adjustments being made for prior estimates which were greater or lesser than the taxes.

Section 1817(b) creates the Board of Trustees of the Trust Fund, to be composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Board of

Trustees will meet at least once each calendar year. The Secretary of the Treasury will be the Managing Trustee of the Board of Trustees, and the Commissioner of Social Security will serve as the Secretary of the Board. The Board of Trustees will (1) hold the Trust Fund; (2) report to the Congress by March 1 of each year on the operation and status of the Trust Fund for the preceding fiscal year and on its expected operation and status for the current fiscal year and the next 2 fiscal years; (3) report immediately to the Congress whenever the Board believes that the amount of the Trust Fund is unduly small; and (4) review the general policies followed in managing the Trust Fund and recommend changes in those policies, including necessary changes in the provisions of the law which govern the way in which the Trust Fund is to be managed. The report on the status and operation of the Trust Fund is to include a statement of the assets of and disbursements from the Fund during the preceding year, an estimate of income and disbursements for the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund, and is to be printed as a House document of the session of the Congress to which the report is made.

Section 1817(c) provides that it is the duty of the Managing Trustee to invest the portion of the Trust Fund which, in his judgment, is not required to meet current withdrawals. These investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. They may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. The Second Liberty Bond Act is extended to authorize the issuance at par, for purchase by the Trust Fund, of public-debt obligations having maturities fixed with due regard for the needs of the Trust Fund and bearing interest at a rate equal to the average market yield on all marketable interest-bearing obligations of the United States which are a part of the public debt at the end of the calendar month preceding the date of issue and which are not due or callable until after 4 years from such month. If the average market yield is not a multiple of one-eighth of one percent, the rate of interest will be the multiple of one-eighth of one percent nearest the market yield. Other interest-bearing obligations of the United States or obligations guaranteed by the United States may be purchased by the Managing Trustee only when he determines it is in the public interest.

Section 1817(d) provides that any obligations acquired by the Trust Fund may be sold by the Managing Trustee at the market price, except public-debt obligations issued exclusively to the Trust Fund, which may be redeemed at par plus accrued interest.

Section 1817(e) provides that the interest on and proceeds from the sale of any obligations held in the Trust Fund will be credited to and form a part of the Fund.

Paragraph (1) of section 1817(f) directs the Managing Trustee to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) of the Internal Revenue Code of 1954 which are subject to refund under section 6413(c) of the Code with respect to wages paid after December 31, 1965. Such taxes are to be determined on the basis of the records of wages established and maintained by the Secretary of Health,

Education, and Welfare in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Code, and the Secretary will furnish the Managing Trustee such information as may be required for this purpose. The payments are to be covered into the Treasury as repayments to the account for refunding internal revenue collections.

Paragraph (2) of section 1817(f) provides that repayments under paragraph (1) will not be available for expenditures but will be carried to the surplus fund of the Treasury.

Section 1817(g) provides for the transfer at least once each fiscal year to the Trust Fund, from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, of amounts equal to the amounts certified by the Secretary as overpayments under section 1870(b). It also provides for the transfer at least once each fiscal year to the Trust Fund from the Railroad Retirement Account of amounts equal to the amounts certified by the Secretary as overpayments to the Railroad Retirement Board under section 1870(b). These amounts represent the overpayments which are to be collected by reducing the cash monthly benefits payable to (or on the wage record of) the individual involved under title II of the Social Security Act or under the Railroad Retirement Act of 1937.

Section 1817(h) provides that the Managing Trustee will also pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the benefits provided by part A and the administrative expenses in accordance with section 201(g)(1) of the Act.

Part B—Supplementary Health Insurance Benefits for the Aged

Section 1831. Establishment of supplementary health insurance program for the aged

Section 1831 establishes a voluntary health insurance program for individuals aged 65 or over to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

Section 1832. Scope of benefits

Section 1832(a) provides that the benefits made available to an individual under the insurance program established by part B consist of—

(1) entitlement to have payment made to him or on his behalf for physicians' services, and for medical and other health services not furnished by (or under arrangements with) a provider of services (such as a hospital or home health agency); and

(2) entitlement to have payment made on his behalf for (A) inpatient psychiatric hospital services for up to 60 days during a spell of illness; (B) home health services for up to 100 visits during a calendar year (without regard to whether or not the individual has been in a hospital); and (C) medical and other health services furnished by a provider of services (or by others under arrangements with them).

Section 1832(b) contains a cross reference to the definitions of "spell of illness", "medical and other health services", and other terms used in part B which are found in section 1861.

SECTION 1833. PAYMENT OF BENEFITS

Section 1833(a) provides that payment will be made from the Federal Supplementary Health Insurance Benefits Trust Fund, in the case of each individual covered under the insurance program established by part B who incurs expenses for services, for 80 percent of the reasonable charges for physicians' services and for medical and other health services described in 1832(a)(1), and for 80 percent of the reasonable cost (as determined under section 1861(v)) of inpatient psychiatric hospital services, home health services, and medical and other health services described in section 1832(a)(2).

Section 1833(b) provides that, before any payment is made by the program for covered expenses incurred by an individual during any calendar year, the individual must meet a deductible of $50. However, the deductible for any year will be reduced by the amount of any expenses which the individual incurred in the last 3 months of the preceding calendar year and which were applied toward the $50 deductible in such preceding year.

Section 1833(c) provides that (notwithstanding any other provision of part B) expenses incurred in any calendar year for the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time will be considered as incurred expenses for purposes of section 1833 (a) and (b) only to the extent of $312.50 or 62½ percent of the expenses, whichever is smaller. When the 80-percent coinsurance under section 1833(a) is applied to these limits, the actual dollar amount which can be paid under part B for such outpatient psychiatric expenses is $250 or 50 percent of the charges, whichever is less (subject to the deductible under section 1833(b) unless other expenses have been used to satisfy it).

Section 1833(d) provides that expenses for whole blood furnished during a spell of illness to an individual in a hospital will be considered as incurred expenses for purposes of section 1833(a) and (b) only if he has already received 3 pints of whole blood during the same spell.

Section 1833(e) provides that payment may not be made under part B for services furnished an individual if such individual is entitled (or would be entitled except that the expenses involved were used in satisfying a deductible) to have payment made for those services under part A.

Section 1833(f) provides that no payment will be made under part B unless the information necessary to determine the amounts due has been furnished.

SECTION 1834. DURATION OF SERVICES

Paragraph (1) of section 1834(a) provides that payment may not be made under part B for inpatient psychiatric hospital services furnished an individual after such services have been furnished to him for 60 days during a spell of illness, and no payment may be made after these services have been furnished to him for a total of 180 days during his lifetime.

Paragraph (2) of section 1834(a) provides that if an individual is an inpatient of a psychiatric hospital on the first day on which he is entitled to benefits under part B (which could be as early as July 1, 1966), the days on which he was an inpatient of such a hospital in the 60-day period immediately before such first day are to be included in determining the 60-day limit under paragraph (1) but not in determining the 180-day limit under such paragraph. For example, if an individual became covered under part B on July 1, 1966, and had been in a psychiatric hospital since June 1, 1966, he would be covered for only his first 30 days as an inpatient of a psychiatric hospital in his spell of illness beginning July 1. However, the 30 days in June would not be counted toward his lifetime maximum of 180 days.

Section 1834(b) provides that payment may not be made under part B for home health services furnished an individual during any calendar year after such services have been furnished to him for 100 visits during the year. The charging of visits in connection with the provision of covered home health items and services for this purpose is to be determined in accordance with regulations.

Section 1834(c) provides that inpatient psychiatric hospital services and home health services will be taken into account for purposes of the limits on duration of coverage prescribed in section 1834 (a)(1) and (b) only if payment under part B is made or would be made if the services had been furnished within such limits and the request and certification requirements described in section 1835(a) had been met for such services.

SECTION 1835. PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

Section 1835(a) provides that payment for the services described in section 1832(a)(2) (inpatient psychiatric hospital services, home health services, and medical and other health services) may be made only to providers of services which have an agreement with the Secretary under section 1866 and only if the requirements of section 1835(a) with respect to requests and certifications are satisfied.

Paragraph (1) of section 1835(a) requires that a written request (signed by the individual who received the services or by another person when it is impracticable for him to do so) be filed for such payment under regulations issued by the Secretary.

Paragraph (2) of section 1835(a) requires that a physician certify (and recertify, in such cases and as often and with such supporting material as may be provided in regulations, but in any event before the 21st day in the case of inpatient psychiatric hospital services received during a continuous period) that—

(A) in the case of inpatient psychiatric hospital services, the services were required to be given on an inpatient basis for psychiatric treatment by or under the supervision of a physician and such treatment could reasonably be expected to improve the condition, or inpatient diagnostic study was medically required;

(B) in the case of home health services, the services were required because the individual was confined to his home (except when receiving services referred to in sec. 1861(m)(7)) and needed intermittent skilled nursing care, or physical or speech therapy, and the services were furnished while the individual is

or was under the care of a physician and under a plan established and reviewed periodically by a physician; or

(C) in the case of medical and other health services, the services were medically required.

Under the last sentence of section 1835(a), to the extent provided by regulations, the certification and recertification requirements of paragraph (2) will be deemed satisfied where a physician makes the certification or recertification at a date later than the day it was required under paragraph (2), if it is accompanied by such medical or other evidence as may be required by regulations.

Paragraph (3) of section 1835(a) provides that, in the case of inpatient psychiatric hospital services, payment may be made only if the services are those which the records of the hospital indicate were furnished during periods when the individual was receiving intensive treatment services, services necessary for a diagnostic study, or equivalent services.

Paragraph (4) of section 1835(a) provides that payment may not be made for inpatient psychiatric hospital services furnished an individual after the 20th day of a continuous stay if the Secretary, before such individual's admission to the hospital, has rendered an adverse decision under section 1866(d) after finding that the hospital is not making utilization reviews of long-stay cases.

Paragraph (5) of section 1835(a) provides that payment may not be made for inpatient psychiatric hospital services furnished an individual during a continuous period after a finding (as described in section 1861(k)(4)) by the physician members of the appropriate utilization review committee that further inpatient psychiatric hospital services are medically unnecessary. If such a finding has been made, payment may be made for services furnished through the 3d day after the day the notice of such finding is received by the hospital.

Section 1835(b) provides that no payment is to be made under part B to a Federal provider of services unless the Secretary determines that the provider is furnishing services to the public generally as a community institution or agency (St. Elizabeths Hospital in Washington, D.C., for example). Payment may not be made to any provider for any item or service which it is required to render at public expense under a law of or contract with the United States.

Section 1835(c) provides that if a psychiatric hospital has acted reasonably and in good faith in assuming that an individual was entitled to benefits under part B, the hospital can receive payment for inpatient hospital services furnished to the individual, even though he is not entitled to have such payment made, prior to notification from the Secretary that the individual is not so entitled. However, this provision would apply only if such payment is precluded solely because the individual has used up his 60 days of entitlement in the spell of illness; and no payment may be made unless the hospital refunds any payment already received from the individual or on his behalf with respect to the services involved. In any event, payment may not be made under this provision for services furnished an individual after the 6th elapsed day after the day of his admission to the hospital (not counting Saturday, Sunday, or a legal holiday as an elapsed day). Payment to the hospital under section 1835(c) would constitute an overpayment to the individual (and could be recovered) under section 1870.

45-399 O—65——11

SECTION 1836. ELIGIBLE INDIVIDUALS

Section 1836 provides that every individual who has attained the age of 65 and is a resident of the United States, and is either a citizen or an alien lawfully admitted for permanent residence, is eligible to enroll in the insurance program established by part B. (However, sec. 104(b)(2) of the bill provides that a person convicted of certain offenses related to the national security may not enroll under pt. B.)

SECTION 1837. ENROLLMENT PERIODS

Section 1837(a) provides that an individual may enroll in the insurance program established by part B only in such manner and form as may be prescribed in regulations, and only during an enrollment period described in section 1837.

Paragraph (1) of section 1837(b) provides that no individual may enroll for the first time under part B more than 3 years after the close of the first enrollment period during which he could have enrolled.

Paragraph (2) of section 1837(b) provides that an individual whose enrollment under part B has terminated may not enroll for a second time unless he does so in a general enrollment period (as provided in section 1837(e)) which begins within 3 years after the effective date of such termination. No individual may enroll under part B more than twice.

Section 1837(c) provides that the initial general enrollment period is to begin on the first day of the second month which begins after the date of enactment of the bill and is to end on March 31, 1966. This initial general enrollment period is open to individuals who meet the eligibility requirements of section 1836 before January 1, 1966.

Section 1837(d) provides that the initial enrollment period for an individual who first meets the eligibility requirements of section 1836 on or after January 1, 1966, is to begin on the first day of the third month before the month in which he first meets the eligibility requirements and is to end 7 months later. For example, if a resident citizen becomes 65 in April 1967, his enrollment period begins with January 1, 1967, and ends with July 31, 1967.

Section 1837(e) provides that there is to be a general enrollment period from October 1 to December 31 of each odd-numbered year beginning with 1967.

SECTION 1838. COVERAGE PERIOD

Section 1838(a) provides that an individual's coverage period (the period during which he is entitled to benefits under the insurance program established by part B and the period for which premiums are due) will begin on July 1, 1966, or on the first day of the third month following the month in which he enrolls in his initial enrollment period pursuant to section 1837(d), or on the July 1 following the month in which he enrolls in a general enrollment period pursuant to section 1837(e), whichever is the latest.

Section 1838(b) provides that an individual's coverage period will continue until his enrollment has been terminated (1) by the filing of notice, during a general enrollment period, that he no longer wishes to participate in the program, or (2) for nonpayment of premiums. The termination of a coverage period by the filing of such a notice will take

effect at the close of December 31 of the year in which the notice is filed; a termination for nonpayment of premiums will take effect on a date determined under regulations, which may provide a grace period of up to 90 days during which overdue premiums may be paid and the coverage period continued.

Section 1838(c) provides that payment may be made under part B only for expenses incurred by an individual during his coverage period.

SECTION 1839. AMOUNTS OF PREMIUMS

Section 1839(a) provides that the monthly premium for each individual enrolled under part B for each month before 1968 is to be $3.

Paragraph (1) of section 1839(b) provides that for each month after 1967 the amount of the monthly premium of each individual enrolled under part B will be determined under paragraph (2).

Paragraph (2) of section 1839(b) provides that the Secretary, between July 1 and October 1 of 1967 and of each odd-numbered year thereafter, will determine and promulgate the dollar amount which is to be applicable for premiums for months occurring in the 2 succeeding calendar years. Such dollar amount will be the amount the Secretary estimates to be necessary so that the aggregate premiums for such 2 succeeding calendar years will equal one-half of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Health Insurance Benefits Trust Fund for the 2 succeeding years. In estimating aggregate benefits payable for any period, the Secretary will include an appropriate amount for a contingency margin.

Section 1839(c) provides that in the case of an individual whose coverage period begins pursuant to an enrollment after his initial enrollment period (as determined by sec. 1837 (c) or (d)), the monthly premium determined under section 1839(b) will be increased by 10 percent of the monthly premium so determined for each full 12 months in which he could have been but was not enrolled. For these purposes there will be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time.

Section 1839(d) provides that if any monthly premium determined under the preceding provisions of section 1839 is not a multiple of 10 cents, it is to be rounded to the nearest multiple of 10 cents.

SECTION 1840. PAYMENT OF PREMIUMS

Paragraph (1) of section 1840(a) provides that the monthly premium of an individual who is entitled to monthly social security benefits under section 202 is to be collected (except as provided in subsec. (d)) by deducting the premium from the amount of such benefits. The deductions called for under this paragraph will be made in accordance with regulations of the Secretary.

Paragraph (2) of section 1840(a) provides that the Secretary of the Treasury is to transfer periodically from the Federal Old-Age and Survivors Insurance Trust Fund, and from the Federal Disability

Insurance Trust Fund (for example, for premiums deducted in the case of a woman aged 65 or over entitled to benefits as the wife of a disability beneficiary under age 65), to the Federal Supplementary Health Insurance Benefits Trust Fund, the total amount deducted under paragraph (1). Such transfers are to be made on the basis of certifications by the Secretary of Health, Education, and Welfare and will be adjusted to the extent that prior transfers were too great or too small.

Paragraph (1) of section 1840(b) provides that the monthly premium of an individual who is entitled to receive an annuity or pension for a month under the Railroad Retirement Act of 1937 is to be collected (except as provided in subsec. (d)) by deducting the premium from such annuity or pension. The deductions called for under this paragraph will be made in accordance with regulations of the Secretary (prescribed after consultation with the Railroad Retirement Board).

Paragraph (2) of section 1840(b) provides that the Secretary of the Treasury is to transfer periodically from the Railroad Retirement Account to the Federal Supplementary Health Insurance Benefits Trust Fund the total amount deducted under paragraph (1). Such transfers are to be made on the basis of certifications by the Railroad Retirement Board and will be adjusted to the extent that prior transfers were too great or too small.

Section 1840(c) provides that if an individual is entitled both to monthly social security benefits under section 202 and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls under part B, or if he becomes simultaneously entitled both to such benefits and such annuity or pension after he enrolls, section 1840(a) will apply (i.e., the deduction for premiums will be made from his social security benefits); except that in the latter case, if the first month for which he was entitled to social security benefits was later than the first month for which he was entitled to a railroad retirement annuity or pension, then section 1840(b) will apply (i.e., the deduction for premiums will continue to be made from such annuity or pension).

Section 1840(d) provides that if an individual estimates that the amount which will be available for deduction under section 1840 (a) or (b) for any premium payment period will be less than the amount of the monthly premiums during that period, so that his premiums could not be deducted from his benefits on a month-to-month basis, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires. For example, if an individual has earnings such that under the retirement test no cash social security benefits are payable to him during a year, he can pay his premiums over the course of the year (in accordance with regulations) rather than having them collected from future benefits.

Section 1840(e) provides that for an individual who participates in the insurance program established by part B but to whom neither section 1840(a) nor 1840(b) applies (i.e., who is neither a social security nor a railroad retirement beneficiary), the premiums are to be paid to the Secretary at such times and in such manner as may be prescribed by regulations.

Section 1840(f) provides that amounts paid to the Secretary under section 1840 (d) or (e) are to be deposited in the Treasury to the credit of the Federal Supplementary Health Insurance Benefits Trust Fund.

Section 1840(g) provides that the premiums for an individual enrolled under part B will be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage period ends.

SECTION 1841. FEDERAL SUPPLEMENTARY HEALTH INSURANCE BENEFITS TRUST FUND

Section 1841(a) creates the Federal Supplementary Health Insurance Benefits Trust Fund, which will consist of amounts deposited in or appropriated to it as provided in part B.

Section 1841(b) creates the Board of Trustees of the Trust Fund, which is to meet at least once each calendar year and will be composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Secretary of the Treasury will be the Managing Trustee of the Board of Trustees, and the Commissioner of Social Security will serve as the Secretary of the Board. The Board of Trustees will (1) hold the Trust Fund; (2) report to the Congress by March 1 of each year on the operation and status of the Trust Fund for the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years; (3) report immediately to the Congress whenever the Board believes that the amount of the Trust Fund is unduly small; and (4) review the general policies followed in managing the Trust Fund and recommend changes therein, including necessary changes in the provisions of the law which govern the way in which the Trust Fund is to be managed. The report on the status and operation of the Trust Fund is to include a statement of the assets of and disbursements from the Fund during the preceding year, an estimate of income and disbursements during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund, and is to be printed as a House document of the session of the Congress to which the report is made.

Section 1841(c) provides that it is the duty of the Managing Trustee to invest the portion of the Trust Fund which, in his judgment, is not required to meet current withdrawals. These investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. They may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. The Second Liberty Bond Act is extended to authorize the issuance at par, for purchase by the Trust Fund, of public-debt obligations having maturities fixed with due regard for the needs of the Trust Fund and bearing interest at a rate equal to the average market yield on all marketable interest-bearing obligations of the United States which are a part of the public debt at the end of the calendar month preceding the date of issue and which are not due or callable until after 4 years from such month. If the average market yield is not a multiple of one-eighth of 1 percent, the rate of interest will be the multiple of one-eighth of 1 percent nearest the market yield. Other interest-bearing obligations of the United States or obligations guaranteed by the United States may be purchased by the Managing Trustee only when he determines it is in the public interest.

Section 1841(d) provides that any obligations acquired by the Trust Fund may be sold by the Managing Trustee at the market price, except public-debt obligations issued exclusively to the Trust Fund, which may be redeemed at par plus accrued interest.

Section 1841(e) provides that the interest on and proceeds from the sale of any obligations held in the Trust Fund will be credited to and form a part of the Fund.

Section 1841(f) provides for the transfer at least once each fiscal year to the Trust Fund, from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, of amounts equal to the amounts certified by the Secretary of Health, Education, and Welfare as overpayments under section 1870(b). It also provides for the transfer at least once each fiscal year to the Trust Fund from the Railroad Retirement Account of amounts equal to the amounts certified by the Secretary as overpayments to the Railroad Retirement Board under section 1870(b). These amounts represent the overpayments which are to be collected by reducing the cash monthly benefits payable to (or on the wage record of) the individual involved under title II of the Social Security Act or under the Railroad Retirement Act of 1937.

Section 1841(g) provides that the Managing Trustee will also pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to to make the payments provided for by part B and the payments for administrative expenses in accordance with section 201(g)(1) of the Act.

SECTION 1842. USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

Section 1842(a) provides that in order to carry out the administration of the voluntary health insurance program established by part B, the Secretary to the extent possible will enter into contracts with carriers which will undertake to perform the functions specified in section 1842(a) or, to the extent provided in the contracts, to secure performance of such functions by other organizations.

Paragraph (1) of section 1842(a) provides that the carriers under contract (or such other organizations) will (A) make determinations of the rates and amounts of payments required pursuant to part B to be made to providers of services and other persons on a reasonable cost or reasonable charge basis, whichever applies; (B) receive, disburse, and account for funds in making such payments; and (C) make audits of the records of providers of services necessary to assure that proper payments are made to them under part B.

Paragraph (2) of section 1842(a) provides that the carriers will determine compliance with the requirements of section 1861(k) as to utilization review, and assist providers and other persons who furnish services for which payment may be made under part B in the development of procedures relating to utilization practices, make studies of the effectiveness of utilization procedures, assist in the application of safeguards against unnecessary utilization of services furnished by providers and other persons to individuals entitled to benefits under part B, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2)) to make reviews of utilization.

Paragraph (3) of section 1842(a) provides that the carriers will serve as a channel of communication of information relating to the administration of the voluntary health insurance program under part B.

Paragraph (4) of section 1842(a) provides that the carriers will assist in discharging other necessary administrative duties, as may be provided in the contract.

Paragraph (1) of section 1842(b) provides that contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

Paragraph (2) of section 1842(b) provides that the Secretary is not to enter into a contract with a carrier unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements relating to financial responsibility, legal authority, and other matters as he finds pertinent.

Paragraph (3) of section 1842(b) provides that each contract must provide that the carrier will—

(A) take necessary action to assure that, where payment under part B for a service is on a cost basis, the cost is reasonable cost (as determined under sec. 1861(v));

(B) take necessary action to assure that, where payment under part B for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will be made on the basis of a receipted bill, or on the basis of an assignment under which the reasonable charge is the full charge for the service;

(C) establish and maintain procedures under which an individual enrolled under part B will be entitled to a fair hearing by the carrier when request for payment is denied or is not acted upon with reasonable promptness or when the amount of payment is in controversy;

(D) furnish to the Secretary such timely information and reports as may be necessary for the Secretary to perform his functions under part B; and

(E) maintain and afford access to whatever records the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D), and otherwise to carry out the purposes of part B.

Each contract shall also contain such other terms and conditions consistent with section 1842 as the Secretary may find necessary or appropriate.

Paragraph (4) of section 1842(b) provides that each contract must be for the term of at least 1 year, and may be made automatically renewable unless either party provides notice of intent to terminate the contract at the end of its current term. However, the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying it out in a manner inconsistent with the efficient and effective administration of the insurance program established by part B.

Section 1842(c) provides that each contract is to provide for advances of funds to the carrier for the making of payments by it under part B, and for payment of the necessary and proper administrative costs of the carrier.

Section 1842(d) provides that any contract may require a carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

Paragraph (1) of section 1842(e) provides that no individual designated pursuant to a contract as a certifying officer will, in the absence of gross negligence or intent to defraud the United States, be liable for any payments incorrectly certified by him.

Paragraph (2) of section 1842(e) provides a similar immunity for disbursing officers who make an incorrect payment based upon a voucher signed by a certifying officer designated as provided in paragraph (1).

Section 1842(f) provides that, for purposes of part B, the term "carrier" means (1) with respect to providers of services and other persons, a voluntary association, corporation, or partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and (2) with respect to providers of services only, any agency or organization (not described in (1)) with which an agreement is in effect under section 1816.

SECTION 1843. STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS

Section 1843(a) provides that the Secretary, at the request of a State made before July 1, 1967, will enter into an agreement with such State to provide coverage under part B for all eligible individuals who are in a coverage group elected by the State from the two groups described in section 1843(b). (For definition of "eligible individual" see section 1836, discussed above.)

Section 1843(b) provides that the agreement entered into with any State under section 1843(a) may be applicable to either of the following groups: (1) aged recipients of money payments under a plan of the State approved under title I or XVI, or (2) aged recipients of money payments under all of the plans of the State approved under titles I, IV, X, XIV, and XVI. However, neither group may include any individual entitled to monthly OASDI benefits or entitled to receive an annuity or pension under the Railroad Retirement Act of 1937.

Section 1843(c) provides that, for purposes of section 1843, coverage under the agreement may be provided only for an individual who is an eligible individual (as described above) on the date the agreement is entered into or who becomes an eligible individual in the period between the date of the agreement and July 1, 1967. He will be

treated as a money payment recipient if he receives a money payment for the month in which the agreement is entered into or any month between such month and July 1967.

Section 1843(d) provides that in the case of any individual enrolled pursuant to an agreement under section 1843—

(1) the monthly premium to be paid by the State is to be determined under section 1839 (without any increase under subsec. (c) thereof);

(2) his coverage period will begin either on July 1, 1966, on the first day of the third month following the month in which the State agreement is entered into, on the first day of the first month in which he is both an eligible individual and a member of the coverage group specified in the agreement, or on a date (not later than July 1, 1967) specified in the agreement, whichever is the latest; and

(3) his coverage period will end on either the last day of the month in which he is determined by the State to have become ineligible for the money payments specified in the agreement, or the last day of the month before the first month for which he becomes entitled to monthly benefits under title II or to an annuity or pension under the Railroad Retirement Act of 1937.

Section 1843(e) provides that any individual whose coverage period attributable to the State agreement is terminated (as described in sec. 1843(d)(3)) will be deemed for purposes of part B (including the continuation of his coverage period) to have enrolled under section 1837 in the initial general enrollment period (ending March 31, 1966) provided by section 1837(c).

Section 1843(f) provides that with respect to individuals receiving money payments under a State plan approved under title I, IV, X, XIV, or XVI, if the agreement so provides, the term "carrier" as defined in section 1842(f) also includes the State agency specified in the agreement which administers or supervises the administration of the State plan approved under title I, XVI, or XIX. Thus, a State agency which meets the definition of "carrier" under section 1843(f) could be considered a carrier with respect to all individuals receiving the specified money payments (including those who are not eligible to be in the coverage group as defined in sec. 1843(b) because they are entitled to monthly social security benefits or a pension or annuity under the railroad retirement system). The agreement with the State will also contain provisions to facilitate the financial transactions of the State and the carrier relating to deductions and coinsurance, in the interest of economy and efficiency of operation, with respect to individuals receiving money payments under the State's plans approved under titles I, IV, X, XIV, and XVI.

SECTION 1844. APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

Section 1844(a) authorizes the appropriation from time to time of a Government contribution, equal to the total premiums payable by individuals who have enrolled under part B, from the Treasury to the Federal Supplementary Health Insurance Benefits Trust Fund.

Section 1844(b) provides that in order to assure prompt payment of benefits and administrative expenses under part B during the early

months of the program, and to provide a contingency reserve, there is also authorized to be appropriated during the fiscal year ending June 30, 1966, for repayable advances (without interest) to the Trust Fund, an amount (to remain available through the next fiscal year) equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by part B if they had theretofore enrolled.

Part C—Miscellaneous Provisions

Section 1861. Definitions of services, institutions, etc.

Section 1861 defines, for purposes of both part A and part B, the terms used in the new title XVIII.

Spell of illness

Section 1861(a) defines the term "spell of illness" to mean a period of consecutive days (1) beginning with the first day (not included in a previous spell) on which the individual is furnished inpatient hospital or extended care services and which occurs in a month for which he is entitled to benefits under part A or B, and (2) ending with the close of the first period of 60 consecutive days thereafter throughout which he is neither an inpatient of a hospital nor an inpatient of an extended care facility. (For special definitions of "hospital" and "extended care facility" for purposes of sec. 1861(a)(2), see discussion of secs. 1861(e) and 1861(j) below.)

Inpatient hospital services

Section 1861(b) defines the term "inpatient hospital services" to mean the following items and services furnished to an inpatient of a hospital (and furnished by the hospital, except as provided in item (3)): (1) bed and board; (2) such nursing services, use of hospital facilities, medical social services, and drugs, biologicals, supplies, appliances, and equipment for use in the hospital as are ordinarily furnished by such hospital for the care and treatment of inpatients; (3) other diagnostic or therapeutic items or services ordinarily furnished by the hospital or by others under arrangements made by the hospital. Excluded from the term "inpatient hospital services" are the services of a private-duty nurse or attendant and medical or surgical services provided by a physician, resident, or intern; except that services of a resident-in-training or intern provided under a teaching program approved by the American Medical Association or the American Osteopathic Association are included in the term.

Inpatient psychiatric hospital services

Section 1861(c) defines the term "inpatient psychiatric hospital services" to mean inpatient hospital services furnished to an inpatient of a psychiatric hospital.

Inpatient tuberculosis hospital services

Section 1861(d) defines the term "inpatient tuberculosis hospital services" to mean inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

Hospital

Section 1861(e) defines the term "hospital" to mean in general an institution which (1) is primarily engaged in providing diagnostic and therapeutic services for medical diagnosis, treatment, and care, or rehabilitation services for injured, disabled, or sick persons; (2) maintains clinical records on all patients; (3) has bylaws in effect with respect to its staff of physicians; (4) requires that every patient be under the care of a physician; (5) provides 24-hour nursing service rendered by or under the supervision of a registered nurse; (6) has in effect a hospital utilization review plan satisfying section 1861(k); (7) is licensed (or meets standards of licensing) pursuant to State or local law; and (8) meets such other requirements as the Secretary finds necessary in the interest of health and safety (except that these requirements may not be higher than the comparable requirements prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals).

For the specific purpose of determining how long an individual is out of a hospital in order to establish when a spell of illness ends, an institution satisfying item (1) of the definition is a "hospital." In determining whether emergency hospital services are covered under section 1814(d), and for purposes of describing the institution from which an individual must be transferred in order to be eligible for post-hospital extended care or post-hospital home health services, an institution satisfying items (1), (2), (3), (4), (5), and (7) of the definition is a "hospital." The term "hospital" does not (except for purposes of determining when a spell of illness ends) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis, except that for purposes of part A the term includes a tuberculosis hospital as defined in section 1861(g) and for purposes of part B the term includes a psychiatric hospital as defined in section 1861(f). The term also includes a Christian Science sanatorium operated or listed and certified by the First Church of Christ Scientist, Boston, Mass., but payment may be made with respect to services provided by or in such a sanatorium only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of those otherwise applicable) as may be provided in regulations.

Psychiatric hospital

Section 1861(f) defines the term "psychiatric hospital" to mean an institution which (1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons; (2) satisfies the requirements prescribed for hospitals under items (3) through (8) of section 1861(e); (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals enrolled under the insurance program established by part B; (4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and (5) is accredited by the Joint Commission on Accreditation of Hospitals. If an institution satisfies requirements (1) and (2) and contains a distinct part which also satisfies requirements (3) and (4), the distinct part will

be considered to be a "psychiatric hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or the distinct part satisfies requirements equivalent to the accreditation requirements of the Joint Commission as determined by the Secretary.

Tuberculosis hospital

Section 1861(g) defines the term "tuberculosis hospital" to mean an institution which (1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis; (2) satisfies the requirements prescribed for hospitals under items (3) through (8) of section 1861(e); (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered under the insurance program established by part A; (4) meets such staffing requirements as the Secretary may find necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and (5) is accredited by the Joint Commission on Accreditation of Hospitals. If an institution satisfies requirements (1) and (2) and contains a distinct part which also satisfies requirements (3) and (4), the distinct part will be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or the distinct part satisfies requirements equivalent to the accreditation requirements of the Joint Commission as determined by the Secretary.

Extended care services

Section 1861(h) defines the term "extended care services" to mean the following items and services furnished to an inpatient of an extended care facility (and furnished by such facility except as provided in items (3) and (6)): (1) nursing care furnished by or under the supervision of a registered nurse; (2) bed and board; (3) physical, occupational, or speech therapy furnished by the facility or others under arrangements with them; (4) medical social services; (5) such drugs, biologicals, supplies, appliances, and equipment as are ordinarily furnished by the facility for care and treatment of inpatients; (6) medical services of interns and residents-in-training under an approved teaching program of a hospital with which such facility has in effect a transfer agreement and certain other services provided by such a hospital; and (7) such other health services as are generally provided by extended care facilities. Any service which would not be covered if furnished to an inpatient of a hospital is excluded.

Post-hospital extended care services

Section 1861(i) defines the term "post-hospital extended care services" to mean extended care services (as defined in sec. 1861(h)) furnished an individual after transfer from a hospital of which he was an inpatient for not less than 3 consecutive days before his discharge. Items and services will be deemed to have been furnished to an individual after transfer from a hospital, and he will be deemed to have been an inpatient of the hospital immediately before transfer, if he is admitted to the extended care facility within 14 days after discharge from such hospital. An individual will be deemed not to have been discharged from an extended care facility if he is readmitted to such facility within 14 days after discharge therefrom.

Extended care facility

Section 1861(j) defines the term "extended care facility" to mean an institution (or a distinct part thereof) which has a transfer agreement with one or more participating hospitals (as described in sec. 1861(l)) and which (1) is primarily engaged in providing to inpatients skilled nursing care and related services, or rehabilitation services; (2) has policies which are developed with the advice of and periodically reviewed by a professional group (including at least one physician and at least one registered nurse) to govern the services it provides; (3) has a physician, registered nurse, or medical staff responsible for the execution of such policies; (4) requires that the health care of each patient be under the supervision of a physician and provides for having a physician available to furnish necessary emergency medical care; (5) maintains clinical records on all patients; (6) provides 24-hour nursing services sufficient to meet needs in accordance with facility policies and has at least one registered professional nurse employed full time; (7) provides appropriate methods for dispensing and administering drugs and biologicals; (8) has in effect a utilization review plan satisfying section 1861(k); (9) is licensed (or meets the standards for licensing) pursuant to State or local law; and (10) meets such other conditions relating to health and safety or physical facilities as the Secretary may find necessary. The term "extended care facility" does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For the specific purpose of determining when a spell of illness ends (under sec. 1861(a)(2)) the term includes any institution which satisfies item (1).

Utilization review

Section 1861(k) provides that a utilization review plan of a hospital or extended care facility will be considered sufficient if it is applicable to services furnished to individuals entitled to benefits under part A or part B and if it provides (1) for the review, on a sample or other basis, of admissions, duration of stays, and professional services from the standpoint of medical necessity and for the purpose of promoting the most efficient use of available health facilities and services; (2) for such review to be made by a staff committee of the institution which includes two or more physicians, or by a similarly composed group outside the institution which is established either by the local medical society and some or all of the hospitals and extended care facilities in the locality or in some other manner which may be approved by the Secretary; (3) for such review (in each case of a continuous stay of extended duration in a hospital or extended care facility) as of such days of such stay (which may be different for different classes of cases) as may be specified in regulations, with such review being made as promptly as possible after each day specified in the regulations but no later than 1 week following that day; and (4) for prompt notification to the institution, the individual, and his physician of any finding (which shall be made only after opportunity for consultation has been provided the physician) that further stay in the institution is not medically necessary. The utilization review plan must provide for review by a group outside the institution where, because of its small size (or, in the case of an extended care facility, because of lack of an organized medical staff), or for such other reasons

as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee.

Agreements for transfer between extended care facilities and hospitals

Section 1861(l) provides that a hospital and an extended care facility will be considered to have a transfer agreement if a written agreement between them (or a written undertaking by the person or body controlling them, in the case of institutions under common control) provides reasonable assurance that (1) there will be timely transfer of patients between the institutions whenever it is determined medically appropriate by the attending physician; and (2) there will be timely transfer between the institutions of medical and other information needed for patients' care or for determining whether patients can be adequately cared for in some other way. Any extended care facility which does not have a transfer agreement in effect, but which is found by a State agency (with which an agreement under sec. 1864 is in effect) or by the Secretary (if there is no such agreement) to have attempted in good faith to enter into such an agreement with a hospital close enough to the facility to make transfer of patients and information between them feasible, will be considered to have a transfer agreement in effect if the agency (or the Secretary) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for benefits under title XVIII.

Home health services

Section 1861(m) defines the term "home health services" to mean the following items and services furnished to an individual who is under the care of a physician, on a visiting basis in his residence (except as provided in item (7)), by a home health agency (or by others under arrangements with such agency) under a plan established and periodically reviewed by a physician: (1) part-time or intermittent nursing care provided by or under the supervision of a registered nurse; (2) physical, occupational, or speech therapy; (3) medical social services under the direction of a physician; (4) to the extent permitted in regulations, part-time or intermittent home health aide services; (5) medical supplies (other than drugs and biologicals) and the use of medical appliances; (6) medical services of interns and residents-in-training under an approved teaching program of a hospital with which the agency is affiliated; and (7) any of the foregoing items and services which (A) are provided on an outpatient basis under arrangements made by the home health agency at a hospital or extended care facility, or at a rehabilitation center meeting such standards as may be prescribed in regulations, and (B) involve the use of equipment of such nature that the items and services cannot readily be made available to the individual in his place of residence, or are furnished at such facility while he is there to receive any item or service involving the use of such equipment (but excluding transportation of the individual in connection with such items or services). Any item or service which would not be covered if furnished to an inpatient of a hospital is excluded.

Post-hospital home health services

Section 1861(n) defines the term "post-hospital home health services" to mean home health services (as defined in sec. 1861(m)) which

(1) are furnished an individual within 1 year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within 1 year after his most recent discharge from an extended care facility of which he was an inpatient entitled to benefits under part A, and (2) are covered by a plan (described above) established within 14 days after his discharge from the hospital or extended care facility.

Home health agency

Section 1861(o) defines the term "home health agency" to mean a public agency or private organization (or a part of such agency or organization) which (1) primarily provides skilled nursing or other therapeutic services; (2) has policies established by a professional group (including at least one physician and at least one registered nurse) to govern services, and provides for supervision of such services by a physician or a registered nurse; (3) maintains clinical records on all patients; (4) is licensed (or meets standards for licensing) pursuant to State or local law; and (5) meets other conditions found by the Secretary to be necessary for health and safety. The term does not include a private organization which is not a nonprofit organization exempt from Federal income taxation unless it is licensed pursuant to State law and meets such additional standards and requirements as may be prescribed by regulations. For purposes of part A, the term does not include any agency or organization which is primarily for the care and treatment of mental diseases.

Outpatient hospital diagnostic services

Section 1861(p) defines the term "outpatient hospital diagnostic services" to mean diagnostic services which are ordinarily furnished to outpatients for purposes of diagnostic study by the hospital or by others under arrangements made by the hospital, and which are furnished in facilities supervised by the hospital or its organized medical staff. The term excludes any services which would not be covered if furnished to an inpatient of a hospital.

Physicians' services

Section 1861(q) defines the term "physicians' services" to mean professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not services provided by an intern or resident-in-training under a teaching program approved as described in sec. 1861(b)).

Physician

Section 1861(r) defines the term "physician" to mean an individual legally authorized by a State to practice medicine and surgery (including osteopathy).

Medical and other health services

Section 1861(s) defines the term "medical and other health services" to mean any of the following items or services (unless such services are otherwise classified as inpatient hospital, extended care, home health, or physicians' services): (1) diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests; (2) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians; (3) surgical

dressings, and splints, casts, and other devices used for reduction of fractures and dislocations; (4) rental of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as the patient's home); (5) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition (but only to the extent provided in regulations); (6) prosthetic devices (other than dental) which replace all or part of an internal body organ (including replacement of such devices); and (7) leg, arm, back, and neck braces, and artificial legs, arms, and eyes (including replacements if required because the patient's physical condition changes).

Drugs and biologicals

Section 1861(t) defines the term "drugs" and the term "biologicals" to mean (except for purposes of the exclusion of drugs and biologicals under home health services) those drugs and biologicals which are included in the United States Pharmacopoeia or the National Formulary, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or which are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing them.

Provider of services

Section 1861(u) defines the term "provider of services" to mean a hospital, extended care facility, or home health agency.

Reasonable cost

Paragraph (1) of section 1861(v) provides that the reasonable cost of any services is to be determined under regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies the amount of the payment determined under such paragraph with respect to the services involved will be considered the reasonable cost of such services. In prescribing these regulations the Secretary must consider, among other things, the principles developed and generally applied by national organizations or established prepayment organizations in computing the amount of payment to be made by third parties to providers of services on account of services furnished to individuals by such providers. Such regulations may provide for determination of the cost of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations must take into account both direct and indirect costs of providers in order that the costs with respect to individuals covered by the insurance programs established by title XVIII will not be borne by individuals not so covered and the costs with respect to individuals not covered will not be borne by the insurance programs. The regulations must also provide for making retroactive corrective adjustments where, for any provider of services for any fiscal period, the total reimbursement produced by methods of determining costs proves to be either inadequate or excessive.

Paragraph (2) of section 1861(v) provides that if a patient receives inpatient services in accommodations which are more expensive than semiprivate accommodations, but which are not medically necessary, the amount of payment may not exceed an amount equal to the reasonable cost of such services if furnished in semiprivate accommodations. If a patient receives other items or services which are more expensive than those for which payment can be made, the Secretary will take into account for purposes of payment no more than the reasonable cost of the services that can be paid for.

Paragraph (3) of section 1861(v) provides that if a patient is placed in accommodations less expensive than semiprivate accommodations for a reason the Secretary determines is not consistent with the program's purpose (and not at the patient's request), payment will be limited to the reasonable cost of semiprivate accommodations minus the difference between the customary charges for semiprivate accommodations and the accommodations furnished.

Paragraph (4) of section 1861(v) defines the term "semiprivate accommodations" to mean two-bed, three-bed, or four-bed accommodations.

Arrangements for certain services

Section 1861(w) provides that the term "arrangements" is limited to arrangements under which receipt of payment by a participating provider of services discharges all financial liability for the services.

State and United States

Section 1861(x) provides that the terms "State" and "United States" have the same meaning as when used in title II of the Social Security Act (i.e., the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa).

SECTION 1862. EXCLUSIONS FROM COVERAGE

Section 1862(a) provides that no payment may be made under part A or part B (regardless of any other provision of title XVIII) for any expenses incurred for items or services (1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; (2) for which the individual furnished such items or services has no legal obligation to pay and which no other person (because of such individual's membership in a prepayment plan or for some other reason) has a legal obligation to provide or to pay for; (3) which are paid for directly or indirectly by a governmental entity (other than under the Social Security Act), except in such cases as the Secretary may specify; (4) which are not provided within the United States; (5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part; (6) which constitute personal comfort items; (7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses (including contact lenses), hearing aids or examinations therefor, or immunizations; (8) where such expenses are for orthopedic shoes or other supportive devices for the feet; (9) where such expenses are for custodial care; (10) where such expenses are for cosmetic surgery or are incurred

in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member; or (11) where such expenses constitute charges imposed by immediate relatives of the individual or members of his household.

Section 1862(b) provides that no payment may be made under part A or part B for any item or service for which payment has been made, or can reasonably be expected to be made, under a workmen's compensation law or plan of the United States or a State. Any payment under part A or part B with respect to any item or service must be conditioned on reimbursement being made to the appropriate Trust Fund for such payment if and when notice or other information is received that payment for such item or service has been made under such a law or plan.

SECTION 1863. CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

Section 1863 provides that the Secretary is to consult with the Health Insurance Benefits Advisory Council (established by sec. 1867), appropriate State agencies, and national listing or accrediting bodies, and may consult with local agencies, in prescribing such conditions for participation for providers of services as may be necessary for health and safety. The conditions may be varied for different areas or classes of institutions, and may be set higher for the institutions or agencies in a particular State at such State's request (but, in the case of hospitals, not higher than the accreditation requirements of the Joint Commission on Accreditation of Hospitals).

SECTION 1864. USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

Section 1864(a) provides that the Secretary is to make an agreement with any State which is able and willing to enter into an agreement to utilize the services of the State health agency or other appropriate State agencies (or the appropriate local agencies) for the purpose of determining which institutions and agencies qualify to participate in the programs under title XVIII. The Secretary may accept a State (or local) agency's findings as to the qualifications of an institution or agency to participate. The Secretary may also, pursuant to agreement, use State and local agencies to do any of the following: (1) provide consultative services to institutions or agencies to assist them in establishing and maintaining fiscal records or otherwise qualifying for participation, or in providing information necessary to determine what benefits are payable; and (2) provide consultative services to institutions, agencies, or organizations to assist them in establishing and evaluating the effectiveness of utilization review procedures.

Section 1864(b) provides that the Secretary is to pay the State for the reasonable costs of the administrative activities performed under its agreement under section 1864(a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of

services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

SECTION 1865. EFFECT OF ACCREDITATION

Section 1865 provides that any hospital accredited by the Joint Commission on Accreditation of Hospitals will be deemed to meet all the requirements in the definition of "hospital" in section 1861(e) except the utilization review requirement. If the Joint Commission requires a utilization review plan (or imposes another requirement serving the same purpose) for accreditation, the Secretary is authorized to find that accredited hospitals meet all the requirements in such definition. The Secretary may also accept the findings of the American Osteopathic Association, or any other national accrediting body, as to the eligibility of institutions and agencies to participate if he finds reasonable assurance that the pertinent requirements of section 1861 are met.

SECTION 1866. AGREEMENTS WITH PROVIDERS OF SERVICES

Paragraph (1) of section 1866(a) provides that any provider of services will be eligible to participate and eligible for payments under title XVIII if it files an agreement with the Secretary not to charge for covered services (except as provided in paragraph (2)) and to make adequate provision for refund of erroneous charges.

Paragraph (2) of section 1866(a) provides that a provider of services may charge an individual the following: (A) the amount of any deductible imposed pursuant to section 1813(a)(1) or (a)(2) or section 1833(b), and in addition an amount equal to 20 percent of the reasonable charges for the items and services furnished (not in excess of 20 percent of the amount customarily charged for such items and services by the provider) for which payment is made under part B (except that, in the case of expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital, the provider may charge the proportion which is appropriate under the limits imposed by sec. 1833(c)); (B) the excess amount of more expensive services and items furnished at the request of the individual; and (C) the cost of the first 3 pints of whole blood furnished during a spell of illness; except that a charge may not be made for the cost of the administration of such blood and no charge can be made if the blood has been replaced on the individual's behalf or arrangements have been made for its replacement. To illustrate the latter provision (taken together with the provisions of secs. 1813(a)(3) and 1833(d)): if a hospital were to charge a beneficiary $25 for a pint of blood which cost the hospital $10 (and which was 1 of the first 3 pints of blood furnished the beneficiary in the spell of illness), the program would not pay the hospital the $10 cost of the blood but there would be deducted from payments otherwise due the hospital the difference between the $10 cost and the $25 charge—i.e., $15; thus, if the hospital collected the $25 from the beneficiary, the hospital would receive no more in payments from the patient and the program than if it had charged the beneficiary only the $10 cost of the blood.

Section 1866(b) provides that an agreement with a provider of services under section 1866(a) may be terminated by the provider at such time and upon such public notice as may be prescribed by regulations. The Secretary could require the agreement to remain in effect for up to 6 months after the provider gives notice. The Secretary may terminate such an agreement if he determines that the provider (A) is not complying with the agreement or the law, (B) is no longer qualified to participate, or (C) has failed to provide data to determine whether payments are due the provider or the amount of such payments, or has refused access to its records for verification. The termination of any agreement with a provider is to be applicable with respect to (1) inpatient hospital services (including inpatient tuberculosis hospital services), inpatient psychiatric hospital services, and post-hospital extended care services furnished to an individual admitted on or after the effective date of termination, (2) home health services furnished under a plan established on or after the effective date of termination or, if the plan is established before the effective date, services furnished after the calendar year in which the termination is effective, and (3) any other items or services furnished on or after the effective date of termination.

Section 1866(c) provides that if the Secretary terminates an agreement, the provider may not file a new agreement unless the Secretary finds that the reason or reasons for termination is or are removed and that there is assurance they will not recur.

Section 1866(d) provides that if the Secretary finds that timely reviews of long-stay cases are not being made by a hospital or extended care facility he may, in lieu of terminating the agreement, deny payment for services furnished an individual after the 20th day of continuous inpatient hospital care or after stays of a prescribed length in an extended care facility. Such a decision denying payment for services may be made only after notice to the provider and the public and will be rescinded when the Secretary finds that the reviews are being made and that there is assurance they will continue to be made. The Secretary may not make any decision denying such payment except after reasonable notice and opportunity for hearing.

SECTION 1867. HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

Section 1867 provides for the creation of a Health Insurance Benefits Advisory Council to advise the Secretary on general policy in the administration of title XVIII and in the formulation of regulations thereunder. The Council is to consist of 16 persons, who are not Federal employees, to be appointed by the Secretary. The Secretary will from time to time appoint one of the members to serve as Chairman. The Council is to include people who are outstanding in fields related to hospital, medical, and other health activities, and at least one person who is representative of the general public. The members are to serve 4-year terms and may not serve continuously for more than 2 consecutive terms. The Secretary may appoint such special advisory professional or technical committees as may be useful. The Council members and members of any advisory or technical committee will be entitled to receive compensation at rates fixed by the Secretary (not exceeding $100 a day). The Council is to meet as frequently as the Secretary finds necessary, but he must call a meeting upon request of 4 members.

SECTION 1868. NATIONAL MEDICAL REVIEW COMMITTEE

Section 1868(a) provides for the creation of a National Medical Review Committee. The Committee is to consist of 9 persons, who are not Federal employees, to be appointed by the Secretary. The members are to be selected from among representatives of organizations and associations of professional personnel in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields; at least one member must be representative of the general public and a majority of the members must be physicians. The members are to hold office for 3-year terms and may not serve continuously for more than 2 terms.

Section 1868(b) provides that the Committee members will be entitled to receive compensation at rates fixed by the Secretary (not exceeding $100 a day).

Section 1868(c) provides that it is the Committee's function to study the utilization of hospital and other medical care and services for which payment can be made under part A or part B with a view to recommending any changes which may seem desirable in the utilization of care and services or the administration of the programs, or in the provisions of title XVIII. The Committee is to make to the Secretary (who is to transmit it promptly to the Congress) an annual report including any recommendations the Committee may have.

Section 1868(d) authorizes the Committee to engage any technical assistance required to carry out its functions. It also provides that the Secretary is to make available the secretarial, clerical, and other assistance and data needed by the Committee.

SECTION 1869. DETERMINATIONS; APPEALS

Section 1869(a) provides that determinations of entitlement to benefits under part A and part B, and of the amount of benefits under part A, are to be made by the Secretary in accordance with regulations.

Section 1869(b) provides that any individual dissatisfied with any determination under section 1869(a) as to entitlement under part A or part B, or as to amount of benefits under part A if the matter in controversy is $1,000 or more, will be entitled to the same hearing and appeal procedures as are now provided in sections 205(b) and 205(g) of the Act.

Section 1869(c) provides that any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination terminating an agreement under section 1866(b)(2), will be entitled to the same hearing and appeal procedures as are now provided in sections 205(b) and 205(g).

SECTION 1870. OVERPAYMENTS ON BEHALF OF INDIVIDUALS

Section 1870(a) provides that any payment under part A or part B to a provider of services for services furnished an individual will be considered as a payment to such individual.

Section 1870(b) provides that where overpayment is made to a provider of services or other person and cannot be recouped from such provider or person, or payment is made under the conditions specified in section 1814(e) or 1835(c) for an individual who is not

entitled to have such payment made, subsequent cash social security benefits or railroad retirement benefits payable to the individual (or, if such individual dies, benefits payable to others based on his earnings) will be reduced in accordance with regulations prescribed by the Secretary after consultation with the Railroad Retirement Board. As soon as practicable after any such adjustment is determined to be necessary, the Secretary (for purposes of sec. 1870 and secs. 1817(g) and 1841(f)) will certify (to the Railroad Retirement Board if adjustment is to be made by decreasing cash payments under the Railroad Retirement Act of 1937) the amount of the overpayment with respect to which the adjustment is to be made.

Section 1870(c) provides there will be no adjustment (or recovery) in any case in which the individual is without fault, or in which the adjustment (or recovery) would defeat the purposes of title II of the act or would be against equity and good conscience.

Section 1870(d) provides that no certifying or disbursing officer will be liable for overpayments where adjustment or recovery is waived or is not completed prior to the death of all persons against whose benefits the adjustment is authorized.

SECTION 1871. REGULATIONS

Section 1871 provides that the Secretary will prescribe the regulations necessary to carry out the administration of the new insurance programs under title XVIII. When used in such title the term "regulations" means (unless the context otherwise requires) regulations prescribed by the Secretary.

SECTION 1872. APPLICATION OF CERTAIN PROVISIONS OF TITLE II

Section 1872 provides that sections 206, 208, 216(j), and 205 (a), (d), (e), (f), (h), (i), (j), (k), and (l) of the act will apply to title XVIII as they do to title II.

SECTION 1873. DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

Section 1873 provides that any designation made in title XVIII, by name, of any nongovernmental organization or publication will not be affected by a change of the name of such organization or publication and will apply to any successor organization or publication which the Secretary finds serves the purpose for which the designation was made.

SECTION 1874. ADMINISTRATION

Section 1874(a) provides that, except as otherwise stated, the programs established by title XVIII are to be administered by the Secretary, who may perform any of his functions directly or by contract.

Section 1874(b) provides that the Secretary may contract with any person, agency, or institution to secure such special data and actuarial and other information as may be necessary in carrying out his functions.

SECTION 1875. STUDIES AND RECOMMENDATIONS

Section 1875(a) provides that the Secretary is to make studies and develop recommendations to be submitted to the Congress relating to the health care of the aged, including studies and recommendations concerning the adequacy of existing personnel and facilities for health care for purposes of the programs under title XVIII; methods for encouraging further development of efficient and economical alternatives to inpatient hospital care; the effect of the deductibles and coinsurance provisions upon beneficiaries, providers of health services, and the financing of the program; and the desirability of broadening or modifying the provisions which authorize payment for additional days of post-hospital extended care services where the maximum number of days of inpatient hospital services in a spell of illness has not been used.

Section 1875(b) instructs the Secretary to make a continuing study of the operation and administration of the insurance programs under title XVIII and to submit to the Congress annually a report concerning the operation of such programs.

SECTION 102. HOSPITAL INSURANCE BENEFITS AND SUPPLEMENTARY HEALTH INSURANCE BENEFITS— (Continued)

Section 102(b) of the bill provides that if an individual was eligible to enroll under the supplementary health insurance program under part B of the new title XVIII before April 1, 1966, but failed to do so before such date, and it is shown to the satisfaction of the Secretary that there was good cause for such failure to enroll, such individual may enroll in the supplementary health insurance program at any time before October 1, 1966. The Secretary will by regulation determine what constitutes good cause. The coverage period (within the meaning of sec. 1838 of the Social Security Act) of an individual enrolling under this provision will begin on the first day of the 6th month after the month in which he enrolls.

SECTION 103. TRANSITIONAL PROVISION ON ELIGIBILITY OF PRESENTLY UNINSURED INDIVIDUALS FOR HOSPITAL INSURANCE BENEFITS

Section 103(a) of the bill provides that anyone who—

(1) has attained age 65 before 1968 (or has earned 3 quarters of coverage for each calendar year after 1965 and before the year of attainment of age 65);

(2) is not entitled to hospital insurance benefits (and would not be entitled to such benefits upon filing application for monthly benefits under section 202 of the Social Security Act), and is not certifiable as a qualified railroad retirement beneficiary (see sec. 105 of the bill, discussed below);

(3) is a resident of the United States, and is a citizen (or has resided in the United States continuously for at least 10 years immediately prior to the month in which he files application under section 103); and

(4) has filed an application under section 103 in accordance with regulations,

will be entitled to benefits under part A of title XVIII beginning with the first month in which he meets these requirements and ending with the month he dies or, if earlier, the month before the month in which he becomes eligible for hospital insurance benefits under section 226 or becomes certifiable as a railroad retirement beneficiary.

Any person who would have met the preceding requirements in any month if he had filed an application before the end of that month will be deemed to have met such requirements for that month if he files an application before the end of the next 12 months. No application will be accepted as a valid application under section 103 if it is filed before the first month in which the individual meets the requirements of paragraphs (1), (2), and (3) above; i.e., an application filed prematurely will not prevent the individual from obtaining benefits under section 103 if he qualifies therefor at a later time.

Section 103(b) of the bill provides that section 103(a) does not apply to any person who (as of the time of his application under such section) (1) is a member of any organization referred to in section 210(a)(17) of the Social Security Act (relating to subversive organizations); (2) has been convicted of any offense listed in section 202(u) of such act; or (3) is eligible, or could have been eligible if he or some other person had taken the appropriate action, for benefits under the Federal Employees Health Benefits Act of 1959.

Section 103(c) authorizes the appropriation to the Federal Hospital Insurance Trust Fund of such sums as the Secretary deems necessary on account of payments made under part A of title XVIII of the Social Security Act to individuals who are entitled to benefits thereunder solely by reason of section 103 of the bill and on account of the additional administrative expenses and loss of interest to the Fund resulting from such payments.

SECTION 104. SUSPENSION IN CASE OF ALIENS; PERSONS CONVICTED OF SUBVERSIVE ACTIVITIES

Paragraph (1) of section 104(a) of the bill amends section 202(t) of the Social Security Act (relating to suspension of benefits for certain aliens outside the United States) by adding a new paragraph which provides that an individual is not entitled to benefits under part A of title XVIII for any month for which his cash social security benefits are suspended under such section.

Paragraph (2) of section 104(a) of the bill amends section 202(u) of the Social Security Act so that the penalty which may be imposed thereunder upon a conviction for subversive activities (namely, the elimination of all earnings credits for the calendar quarter in which the conviction occurs and prior quarters) will apply to a determination of entitlement to benefits under part A of title XVIII, as well as to the determination of entitlement to cash benefits under title II as provided in existing law.

Paragraph (1) of section 104(b) of the bill provides that payments may not be made under part B of title XVIII for expenses incurred by an individual for any month for which he may not be paid cash benefits under title II by reason of section 202(t) (relating to suspension of benefits for certain aliens who are outside the United States).

Paragraph (2) of section 104(b) of the bill provides that an individual convicted of any of the offenses stipulated in section 202(u) of the Social Security Act may not enroll under part B of title XVIII.

SECTION 105. RAILROAD RETIREMENT AMENDMENTS

Paragraph (1) of section 105(a) of the bill adds a new section 21 to the Railroad Retirement Act of 1937 to provide that, in order to make available hospital insurance benefits under part A of title XVIII of the Social Security Act (added by sec. 102 of the bill) for annuitants, pensioners, and certain other aged individuals under the railroad retirement system, the Railroad Retirement Board is to certify to the Secretary of Health, Education, and Welfare, upon the Secretary's request, the name of any individual who has attained age 65 and—

(1) is entitled to an annuity or pension under the Railroad Retirement Act, or

(2) would be entitled to an annuity under such act if he (or, in the case of a spouse, the spouse's husband or wife) had stopped working in employment covered under such act and applied for such annuity, or

(3) bears a relationship to an employee which by reason of section 3(e) of such act (providing a minimum for the amounts of railroad retirement annuities which is based on the social security benefit formula) has been, or would be, taken into account in calculating the amount of the annuity of such employee or his survivors.

The certification made by the Board to the Secretary of Health, Education, and Welfare is to include such additional information as may be necessary to carry out the hospital insurance benefit provisions, and will be effective on the date of certification or on such earlier date (not more than 1 year prior to the date of certification) as the Board specifies as the date on which the individual first met the requirements for certification. The Board is to notify the Secretary of the date on which the individual no longer meets the requirements.

Paragraph (2) of section 105(a) of the bill provides that, for purposes of section 21 of the Railroad Retirement Act of 1937 (and secs. 1840, 1843, and 1870 of the Social Security Act), entitlement to an annuity or pension under the Railroad Retirement Act of 1937 is deemed to include entitlement under the Railroad Retirement Act of 1935.

Section 105(b) of the bill amends sections 3201, 3211, and 3221(b) of the Railroad Retirement Tax Act (ch. 22 of the Internal Revenue Code of 1954), relating to the rate of tax on employees, on employee representatives, and on employers, respectively. The amendments change the references to section 3101 of the Code in those sections to section 3101(a) to conform to the amendment to section 3101 made by section 321(b) of the bill. A clarifying change is made in each such section by adding a specific reference to the rate of tax (2¾ percent) provided under the Social Security Amendments of 1956. The amendments made by section 105(b) are effective with respect to compensation for services rendered after December 31, 1965.

Section 105(c) of the bill contains a cross reference to section 326 of the bill, which amends the Railroad Retirement Act of 1937 to preserve the existing relationship between the railroad retirement and old-age, survivors, and disability insurance systems.

SECTION 106. MEDICAL EXPENSE DEDUCTION

Allowance of deduction

Section 106(a) of the bill amends section 213(a) of the Internal Revenue Code of 1954 (relating to allowance of deduction for medical expenses).

Under existing law, the general rule is that a taxpayer may deduct expenses for the medical care of himself, his spouse, and his dependents; but only to the extent that they exceed 3 percent of adjusted gross income. The 3-percent limitation is not applicable, however, in the case of expenses paid by the taxpayer (1) for the medical care of a dependent mother or father of the taxpayer or his spouse, if such mother or father has attained the age of 65 before the close of the taxable year, or (2) for the medical care of the taxpayer or his spouse if either has attained the age of 65 before the close of the taxable year.

Section 106(a) of the bill revises section 213(a) by dividing it into two paragraphs, each of which describes a separate part of the total medical expense deduction allowable.

3-percent limitation

Under paragraph (1) of section 213(a), as amended by the bill, the taxpayer (regardless of age) may deduct expenses for the medical care of himself, his spouse, and his dependents only to the extent that such expenses exceed 3 percent of adjusted gross income. The 3-percent limitation is applicable to the expenses for the taxpayer, his spouse, and his dependents whether or not the taxpayer, his spouse, or his dependents have attained the age of 65 before the close of the taxable year. In determining the amount deductible under paragraph (1) of section 213(a) (that is, the amount subject to the 3-percent limitation), there is excluded the amount deductible under the revised paragraph (2) with respect to expenses paid for insurance which constitutes medical care.

Insurance constituting medical care

Under paragraph (2) of section 213(a), as amended by the bill, the taxpayer may deduct an amount equal to one-half of the expenses paid during the taxable year for insurance which constitutes medical care (as such term is defined in section 213(e) as amended by section 106(c) of the bill) for the taxpayer, his spouse, or a dependent. The maximum amount deductible under paragraph (2) is $250.

Example.—Assume that A has medical care expenses for the year (excluding amounts paid for medical care insurance) of $800 which are for himself and his spouse; that A has paid during the year $600 for insurance which constitutes medical care for himself and his spouse; and that A has adjusted gross income of $5,000. A's deduction under the new section 213(a)(2) is $250 (one-half of $600 but not in excess of $250). His deduction under section 213(a)(1) is $1,000 (whether or not A or his spouse is age 65) computed as follows:

Total medical care expenses (including insurance)	$1,400
Less: Expenses for insurance deductible under sec. 213(a)(2)	250
	1,150
Less: 3 percent of adjusted gross income of $5,000	150
Medical expense deduction under sec. 213(a)(1)	1,000

A's total section 213 deduction is $1,250 ($1,000 under paragraph (1), plus $250 under paragraph (2)).

Limitation with respect to medicine and drugs

Section 106(b) of the bill amends section 213(b) of the code (relating to the limitation with respect to medicine and drugs).

Section 213(b) of the code provides as a general rule that in computing his medical expense deduction, the taxpayer shall take into account only the aggregate of the amounts paid for medicine and drugs in excess of 1 percent of adjusted gross income. However, the 1-percent limitation does not apply to amounts paid during the taxable year for medicines and drugs (1) for the care of the taxpayer and his spouse if either has attained age 65 before the close of the taxable year, or (2) for the care of the mother or father of the taxpayer or his spouse if such parent is a dependent (as defined in sec. 152 of the code) of the taxpayer or his spouse and has attained age 65 before the close of the taxable year. Section 106(b) of the bill repeals the exceptions to the 1-percent limitation. Thus, under the bill, the 1-percent floor applies to all expenses for drugs and medicines without exception.

Definition of medical care

Section 106(c) of the bill strikes out paragraph (1) of section 213(e) of the code (which defines medical care to mean amounts paid (A) for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance), or (B) for transportation primarily for and essential to medical care described in (A)) and replaces it with new paragraphs (1), (2), and (3). The existing paragraph (2) is renumbered as paragraph (4). No substantive change is made in the definition of medical care except as it relates to amounts paid for insurance.

Under the new paragraph (1), subparagraphs (A) and (B) are the same as existing law except for the elimination of the phrase "including amounts paid for accident or health insurance". Under the new subparagraph (C), amounts paid for an insurance contract are included within the definition of medical care only to the extent that the premiums are attributable to insurance covering medical care (as defined in subparagraphs (A) and (B) of section 213(e)(1)). In determining whether a contract constitutes an "insurance" contract, it is irrelevant whether the benefits are payable in cash or services. Under the new paragraph (1)(C), premiums paid under part B of title XVIII of the Social Security Act (relating to supplementary health insurance for the aged) are amounts paid for insurance. Taxes paid under section 1401 (relating to tax on self-employment income) or under section 3101 (relating to tax on income of employees) of the Internal Revenue Code do not constitute amounts paid for insurance.

If amounts are payable under an insurance contract for other than medical care (such as an indemnity for loss of income or for loss of life, limb, or sight) then, under the new paragraph (2), no amount paid for such contract is to be treated as medical care unless (1) the contract specifies what part of the premium is attributable to insurance for medical care, and (2) the part of the premium specified in the contract as being so attributable is a reasonable amount in relation to the total premium under the contract. Moreover, the amount to

be treated as expenses for medical care in such a case is not to exceed the amount so specified in the contract.

Certain prepaid insurance

Under the new paragraph (3) added to section 213(e) of the code, subject to the limitations of the new paragraph (2), premiums paid during a taxable year by a taxpayer before he attains the age of 65 for insurance covering medical care for the taxpayer, his spouse, or a dependent after the taxpayer attains the age of 65 are to be treated as expenses paid during the taxable year for insurance which constitutes medical care if premiums for such insurance are payable (on a level payment basis) under the contract—

(1) for a period of 10 years or more, or

(2) until the year in which the taxpayer attains age 65 (but in no case for a period of less than 5 years).

Maximum limitation in certain cases

Section 106(d) of the bill amends section 213(g) of the code (which provides for an increased maximum limitation on the medical expense deduction allowable to a taxpayer who has attained the age of 65 and is disabled or whose spouse has attained the age of 65 and is disabled) to eliminate the requirement of attaining age 65 so that the increased maximum limitation is applicable in any case where either the taxpayer or his spouse is disabled.

Effective date

Section 106(e) of the bill provides that the amendments made by section 106 shall apply to taxable years beginning after December 31, 1966.

SECTION 107. RECEIPTS FOR EMPLOYEES MUST SHOW TAXES SEPARATELY

Section 107 of the bill amends section 6051(c) of the Internal Revenue Code of 1954 to provide that the statement (form W–2) furnished to an employee pursuant to section 6051 of the code must show the proportion of the amounts withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

SECTION 108. TECHNICAL AND ADMINISTRATIVE AMENDMENTS RELATING TO TRUST FUNDS

Paragraph (1) of section 108(a) of the bill amends section 201(a)(3) of the Social Security Act to exclude the taxes imposed on employers and employees for hospital insurance under sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954, as amended by section 321 of the bill, from the employer and employee taxes appropriated to the Federal Old-Age and Survivors Insurance Trust Fund.

Paragraph (2) of section 108(a) of the bill amends section 201(a)(4) of the act to exclude the taxes imposed on the self-employed for hospital insurance under section 1401(b) of the Code, as amended by section 321 of the bill, from the self-employment taxes appropriated to the Federal Old-Age and Survivors Insurance Trust Fund.

Paragraph (3) of section 108(a) of the bill amends section 201(g)(1) of the act, relating to payments from the trust funds to the Treasury

as reimbursement for administrative costs of title II of the act and chapters 2 and 21 of the Internal Revenue Code of 1954.

The new subparagraph (A) of section 201(g)(1) provides for payment from any or all of the Trust Funds (which include for this purpose the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Health Insurance Benefits Trust Fund) of the costs to the Department of Health, Education, and Welfare of administering titles II and XVIII of the act and for adjustments during, and after the close of, each fiscal year among the Trust Funds so that each fund bears its proportionate share of the costs of administering titles II and XVIII.

The new subparagraph (B) of section 201(g)(1) provides for payments from the Trust Funds to the Treasury to meet the estimated quarterly costs to the Treasury of the administration of titles II and XVIII of the act and of chapters 2 and 21 of the Internal Revenue Code of 1954.

Paragraph (4) of section 108(a) of the bill amends section 201(g)(2) of the act to specify that in estimating the amount of employee taxes subject to refund the Managing Trustee of the old-age, survivors, and disability insurance trust funds shall consider only the taxes imposed for the support of the old-age and survivors insurance and disability insurance programs. (This provision conforms with the provisions of the new section 1817(f) of the act for estimating amounts of employee taxes imposed for the hospital insurance program that are subject to refund because of overpayment.)

Paragraph (5) of section 108(a) of the bill amends section 201(h) of the act to specify that payments made under the new section 226 of the act (relating to entitlement to hospital insurance benefits) are not to be made from the Federal Old-Age and Survivors Insurance Trust Fund.

Section 108(b) of the bill amends section 218(h)(1) of the act (relating to the depositing in the trust funds of amounts received by the Secretary of the Treasury under agreements for coverage of State and local government employees) to provide for proportionate deposits in the Federal Hospital Insurance Trust Fund as well as in the existing trust funds.

Section 108(c) of the bill amends section 1106(b) of the act so that the two new insurance trust funds established by the bill, like the old-age, survivors, and disability insurance trust funds, may be reimbursed for costs of furnishing information (disclosure of which is authorized by regulations) or services to individuals or organizations.

SECTION 109. ADVISORY COUNCIL ON SOCIAL SECURITY

Section 109 of the bill replaces the existing provision for the appointment of Advisory Councils on Social Security Financing with a new provision for the appointment of Advisory Councils on Social Security.

Section 109(a) of the bill adds a new section 706 to title VII of the Social Security Act to provide for the appointment by the Secretary of Health, Education, and Welfare of an Advisory Council on Social Security in 1968 and every fifth year thereafter to review the status of the 4 named trust funds in relation to the long-term commitments of the old-age, survivors, and disability insurance program,

the hospital insurance program, and the supplementary health insurance benefits program and to review also the scope of coverage and the adequacy of benefits under, and all other aspects of, these programs, including their impact on the public assistance programs. Each Council is to consist of the Commissioner of Social Security, as chairman, and 12 members who will, to the extent possible, represent organizations of employers and employees in equal numbers, and represent self-employed persons and the public. The Councils are authorized to engage technical assistance, including actuarial services, and the Secretary is required to make available to the Council secretarial, clerical, and other assistance and such pertinent data prepared by the Department of Health, Education, and Welfare as the Council might require. While serving on business of the Council, the members of the Council will receive compensation at rates fixed by the Secretary but not exceeding $100 per day, and, while serving away from their homes or regular places of business, they will be allowed travel expenses, including per diem in lieu of subsistence. Each Council is to make reports of its findings and recommendations to the Secretary of Health, Education, and Welfare for transmission to the Congress and to the Board of Trustees of each of the 4 trust funds not later than January 1 of the second year after the year in which it was appointed, and then will cease to exist. Separate reports are required with respect to (1) the old-age, survivors, and disability insurance program, (2) the hospital insurance program, and (3) the supplementary health insurance benefits program.

Section 109(b) of the bill repeals section 116(e) of the Social Security Amendments of 1956 (which is the section presently providing for the appointment by the Secretary in 1966 and every fifth year thereafter of an Advisory Council on Social Security Financing with functions limited to review of the financing aspects of the program).

SECTION 110. MEANING OF TERM "SECRETARY"

Section 110 of the bill provides that, as used in the bill and in the provisions of the Social Security Act amended thereby, the term "Secretary" (unless the context otherwise requires) means the Secretary of Health, Education, and Welfare.

PART 2—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SECTION 121. ESTABLISHMENT OF PROGRAMS

Section 121(a) of the bill adds a new title XIX, providing grants to States for medical assistance programs, to the Social Security Act.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SECTION 1901. APPROPRIATION

Section 1901 authorizes the appropriation for each fiscal year of a sum sufficient to carry out the purposes of title XIX, in order to enable each State (as far as practicable under the conditions in such State) to furnish medical assistance on behalf of aged, blind, or

permanently and totally disabled individuals and families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services, and rehabilitation and other services to help such individuals and families attain or retain capability for independence or self-care. The sums made available under this section are to be used for making payments to States which have submitted and had approved State plans for medical assistance. (Sec. 1903(a) provides that such payments are to be made beginning with the quarter commencing January 1, 1966.)

SECTION 1902. STATE PLANS FOR MEDICAL ASSISTANCE

Section 1902(a) sets forth the requirements with which a State plan for medical assistance must comply in order to be approved by the Secretary of Health, Education, and Welfare and thereby qualify the State for payments under title XIX. To be approved, such a State plan must—

(1) provide that it will be in effect in all political subdivisions of the State and, if the plan is administered by the subdivisions, that it be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which Federal financial participation under section 1903 is authorized and, effective July 1, 1970, provide for State financial participation equal to all of such non-Federal share;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or not acted upon with reasonable promptness;

(4) provide methods of administration of the plan as found necessary by the Secretary for its proper and efficient operation; these would include (A) methods relating to the establishment and maintenance of personnel standards on a merit basis, with the Secretary being precluded from exercising any authority in connection with the selection, tenure, or compensation of any individual employed in accordance with these methods, and (B) provision for utilization of professional medical personnel in the administration of the plan, and in supervision of such administration where the plan is administered locally;

(5) provide that the State agency administering or supervising the State old-age assistance plan approved under title I, or the State plan for aid to the aged, blind, or disabled approved under title XVI (insofar as it relates to the aged), will administer the plan for medical assistance or supervise its administration; and that any local agency administering the State's plan approved under title I or under title XVI (insofar as it relates to the aged) in a political subdivision will administer the plan for medical assistance in that subdivision;

(6) provide that the State agency will make reports as required by the Secretary, and will comply with provisions found necessary by the Secretary to assure their correctness and verification;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the plan's administration;

(8) provide for affording all individuals who wish to do so an opportunity to apply for medical assistance under the plan and for furnishing such assistance with reasonable promptness to all applicants who are eligible for assistance under the plan;

(9) provide for a State authority or authorities with responsibility to establish and maintain standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services;

(10) provide for making medical assistance available to all individuals receiving old-age assistance, aid to families with dependent children, aid to the blind, aid to the permanently and totally disabled, and aid to the aged, blind, or disabled under the State's plans approved under titles I, IV, X, XIV, and XVI of the act; and—

(A) provide that the medical assistance made available to individuals receiving aid or assistance under any one of such plans—

(i) will not be less in amount, duration, or scope than the medical assistance made available to individuals receiving aid or assistance under any other such plan; and

(ii) will not be less in amount, duration, or scope than medical assistance made available to individuals not receiving aid or assistance under any such plan; and

(B) if the plan under title XIX includes medical assistance for any group of individuals who are not recipients under any such plan and do not meet the State's income and resource requirements under the one of such plans which, as determined in accordance with standards prescribed by the Secretary, is appropriate, provide—

(i) for making medical assistance available to all individuals who if needy would be eligible for aid or assistance under any such plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the cost of necessary medical care and services, and

(ii) that the medical assistance made available to all individuals who are not recipients under any such State plan will be equal in amount, duration, and scope;

(11) provide for entering into cooperative arrangements with the State agencies responsible for health and vocational rehabilitation services looking toward maximum utilization of these services in providing medical assistance under the plan;

(12) provide that in determining blindness an examination will be made either by a physician skilled in diseases of the eye or by an optometrist, as the individual may select;

(13) provide for inclusion of some institutional and some noninstitutional care and services and, as of July 1, 1967, for the inclusion of at least (1) inpatient hospital services, (2) outpatient hospital services, (3) other laboratory and X-ray services, (4) skilled nursing home services, and (5) physicians' services (as listed in section 1905(a)); and for the payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan;

(14) provide that—

(A) no deduction, cost sharing, or similar charge will be imposed on any individual with respect to inpatient hospital services furnished him under the plan, and

(B) any deduction, cost sharing, or similar charge imposed as to any other care or services furnished him thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, will be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or to his income and resources;

(15) in the case of eligible individuals 65 years of age or older covered by either or both of the insurance programs (hospital insurance benefits for the aged, and supplementary health insurance benefits for the aged) established by the bill, provide—

(A) for meeting the full cost of any deductible imposed with respect to any such individual under such hospital insurance benefits program; and

(B) where, under the plan, all of a deductible, cost sharing, or similar charge imposed with respect to any such individual under such supplementary health insurance benefits program is not met, the portion which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or to his income and resources;

(16) include, to the extent required by regulations of the Secretary, provisions (conforming to such regulations) regarding the furnishing of medical assistance to eligible residents who are absent from the State;

(17) include reasonable standards, comparable for all groups, for determining eligibility for and the extent of medical assistance under the plan, which standards—

(A) are consistent with the objectives of title XIX,

(B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or re-recipient and (in the case of any applicant or recipient who if he met the State's need requirements would be eligible for aid or assistance in the form of money payments under the State's plan approved under title I, IV, X, XIV, or XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for and the amount of aid or assistance under such plan,

(C) provide for reasonable evaluation of any such income or resources, and

(D) do not take into account the financial responsibility of any individual for any applicant or recipient unless such applicant or recipient is the individual's spouse or is his child who is under age 21 or, if the child is age 21 or over, is blind or permanently and totally disabled; and providm of flexibility in the application of such standards with ree for to income by taking into account, except to the extenspectr scribed by the Secretary, the costs (whether in the ft pre-o

insurance premiums or otherwise) incurred for medical care or any other type of remedial care recognized under State law;

(18) provide that property liens will not be imposed, on account of medical assistance provided under the plan, during a recipent's lifetime (except pursuant to a judgment of a court on account of benefits incorrectly paid), and preclude adjustments or recovery of medical assistance correctly paid except from the estate of a recipient who was at least age 65 when he received such assistance, and then only after the death of his surviving spouse and at a time when he has no surviving child who is under 21, blind, or permanently and totally disabled;

(19) provide safeguards necessary to assure that eligibility for care and services under the plan will be determined and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years or older who are patients in institutions for tuberculosis or mental diseases—

(A) provide for agreements or other arrangements, with State authorities concerned with mental diseases or tuberculosis (as the case may be) and, where appropriate, with such institutions, necessary for carrying out the State plan. These will include arrangements for joint planning and for development of alternate methods of care, for assuring immediate readmittance to institutions where needed for individuals under alternate plans of care, for providing for access to patients and facilities, and for submitting information and reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided is in his best interests, including assurances of initial and periodic review of his medical and other needs, of his receiving appropriate medical treatment within the institution, and of periodic determination of his need for continued institutional care;

(C) provide for the development of alternate plans of care with maximum utilization of available resources for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services to help such recipients and patients attain or retain capability for self-care or other services to prevent or reduce dependency which are appropriate; and for methods of administration necessary to assure that the State plan with respect to these recipients and patients will be effectively carried out; and

(D) provide methods of determining the reasonable cost of institutional care for such patients; and

(21) if the State plan includes medical assistance in behalf of individuals 65 years or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward a comprehensive mental health program.

Section 1902(a) also provides that, notwithstanding the requirement in paragraph (5) above, any State which (on January 1, 1965, and on the date it submits its plan under title XIX) administers or supervises

its program for the blind under title X (or under title XVI, insofar as it relates to the blind) through a State agency other than the State agency that administers or supervises its title I plan (or title XVI plan, insofar as it relates to the aged) will be permitted, upon coming under title XIX, to retain such separate blind program agency to administer or supervise (as a separate State plan, except for purposes of paragraph (10) above) the portion of the approved plan for medical assistance under title XIX which relates to blind individuals.

Section 1902(b) requires the Secretary of Health, Education, and Welfare to approve any plan which fulfills the conditions spec. fied in section 1902(a), except that he is not to approve any plan which imposes as a condition of eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and who meets the definition of a dependent child under title IV of the act disregarding the provisions of section 406(a)(2); or

(3) any residence requirement which excludes any individual residing in the State; or

(4) any citizenship requirement which excludes any citizen of the United States.

Section 1902(c) requires the Secretary, notwithstanding the fact that a State plan is otherwise approvable, not to approve such plan if he determines that its approval and operation will result in a reduction in aid or assistance (other than so much as is provided under the approved title XIX plan) provided for eligible individuals under the State's plan approved under title I, IV, X, XIV, or XVI.

SECTION 1903. PAYMENT TO STATES

Section 1903(a) provides for making Federal payments to States with respect to expenditures for programs of medical assistance under approved plans. Except as otherwise provided in section 1903 and in section 1117 (as added to title XI of the Social Security Act by sec. 405 of the bill), the Secretary will pay each State with an approved plan for medical assistance, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in sec. 1905(b)) of the total medical assistance expenditures during the quarter, including in such expenditures premiums under part B of title XVIII (relating to supplementary health insurance benefits for the aged) for recipients of money payments under title I, IV, X, XIV, or XVI, and other insurance premiums for medical or remedial care or the cost of such care; plus

(2) an amount equal to 75 percent of the amounts expended during the quarter for administrative costs attributable to compensation of skilled professional medical personnel and directly-supporting staff of the State agency or local agency administering the plan; plus

(3) one-half of the remaining administrative expenses.

Section 1903(b) provides that, notwithstanding the provisions of section 1903(a), the amount of the Federal payment for any quarter

attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for tuberculosis or mental diseases is to be paid only to the extent that total expenditures from Federal, State, and local funds for mental health services under State and local public health and public welfare programs for the quarter are shown to the satisfaction of the Secretary to exceed the average of the total expenditures for these services for each quarter of the fiscal year ending June 30, 1965. The expenditures for these services for each quarter in the fiscal year ending June 30, 1965, are to be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination under section 1903(b); and expenditures for any quarter beginning after December 31, 1965, are to be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination for such State for such quarter. For the purposes of section 1903(b), such determinations will be conclusive.

Section 1903(c) provides that if the Secretary finds, on the basis of satisfactory information submitted by a State, that its Federal medical assistance percentage applicable to any quarter during the period January 1, 1966, through June 30, 1969, is less than 105 percent of the Federal share of the State's medical expenditures during the fiscal year ending June 30, 1965, then its Federal medical assistance percentage will be 105 percent of such Federal share instead of the percentage determined under section 1905(b). Such adjusted percentage will be applicable for such quarter and each subsequent quarter in such period prior to the first quarter as to which such finding is not applicable.

For the above purposes, such Federal share means the percentage which the excess of—

(A) the total of the amounts of the Federal shares (determined under the applicable formulas of the public assistance titles of the act) of the State's expenditures for aid or assistance in any form during fiscal year 1965 under its plans approved under titles I, IV, X, XIV, and XVI over

(B) the total of the Federal shares determined under such formulas with respect to its expenditures of aid or assistance during such year, excluding aid or assistance in the form of medical or remedial care,

is of the total of aid or assistance expenditures in the form of medical or remedial care under such plans during such year.

Section 1903(d) provides procedures for paying to a State the amounts to which it is entitled under the preceding provisions of section 1903. These are, with appropriate modifications, similar to those under the existing public assistance titles of the act.

Section 1903(e) provides that payments under the preceding provisions of section 1903 are not to be made unless the State makes a satisfactory showing that it is making efforts toward broadening the scope of the care and services available under its plan and toward liberalizing the eligibility requirements for medical assistance, looking toward providing, by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility requirements with respect to income and resources, including services to help such individuals to attain independence or self-care.

SECTION 1904. OPERATION OF STATE PLANS

Section 1904 provides for withholding of Federal payments to a State if the Secretary finds, after reasonable notice and opportunity for hearing to the State agency having responsibility for the plan, that the approved plan has been so changed that it no longer complies with the provisions of section 1902 or that in the administration of the plan there is failure to comply substantially with any such provision. Until the Secretary is satisfied that there is no longer any failure to comply, he will make no further payments to the State or in his discretion will limit payments to categories under or parts of the plan not affected by such failure.

SECTION 1905. DEFINITIONS

Section 1905(a) defines the term "medical assistance" to mean payment of part or all of the cost of the following care and services (if provided in or after the third month before the month the recipient makes application) for individuals who are under the age of 21 and who except for section 406(a)(2) are (or would, if needy, be) dependent children as defined under title IV, or who are relatives specified in section 406(b)(1) with whom such children are living, or who are 65 years of age or older, are blind, or are 18 years of age or older and permanently and totally disabled, but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services;
(2) outpatient hospital services;
(3) other laboratory and X-ray services;
(4) skilled nursing home services;
(5) physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere;
(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;
(7) home health care services;
(8) private duty nursing services;
(9) clinic services;
(10) dental services;
(11) physical therapy and related services;
(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;
(13) other diagnostic, screening, preventive, and rehabilitative services; and
(14) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

but the term does not include—

(A) payments with respect to care or services for an individual who is an inmate of a public institution (except as a patient in a medical institution); or
(B) payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

Section 1905(b) defines the term "Federal medical assistance percentage". Such percentage for a State is 100 per centum minus the percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the 50 States and the District of Columbia. Such percentage is in no case less than 50 per centum or more than 83 per centum, except that for Puerto Rico, the Virgin Islands, and Guam it is set at 55 per centum. Determination and promulgation by the Secretary of the Federal medical assistance percentage will be in accordance with the provisions of section 1101(a)(8)(B) of the act, except that such promulgation will be made as soon as possible after enactment of the bill and it will be conclusive for each of the 6 quarters in the period January 1, 1966, through June 30, 1967.

SECTION 121. ESTABLISHMENT OF PROGRAMS—(Con.)

Section 121(b) of the bill provides that no payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act for aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX (as added to such act by sec. 121(a) of the bill), or for any period after June 30, 1967.

Paragraph (1) of section 121(c) of the bill (effective January 1, 1966) amends section 1101(a)(1) of the act to make a necessary conforming change.

Paragraph (2) of section 121(c) of the bill amends section 1109 of the act to provide that any amount which is disregarded (or set aside for future needs) in determining eligibility for and amount of the aid or assistance for an individual under a State plan approved under title I, IV, X, XIV, XVI, or XIX of the act is not to be taken into consideration in determining the eligibility for or amount of medical assistance for any other individual under a State plan approved under such title XIX.

Paragraph (3) of section 121(c) of the bill (effective January 1, 1966) amends section 1115 of the act to make necessary conforming changes.

SECTION 122. PAYMENT BY STATES OF PREMIUMS FOR SUPPLEMENTARY HEALTH INSURANCE

Section 122 of the bill amends sections 3(a), 403(a), 1003(a), 1403(a), and 1603(a) of the Social Security Act to authorize Federal financial participation in expenditures by a State under its approved plans under the respective public assistance titles of such act for premiums paid for supplementary health insurance benefits for the aged (the insurance program under part B of title XVIII of the Social Security Act, as added by the bill) for individuals who receive money payments under any such title.

TITLE II—OTHER AMENDMENTS RELATING TO HEALTH CARE

Part 1—Maternal and Child Health and Crippled Children's Services

SECTION 201. INCREASE IN MATERNAL AND CHILD HEALTH SERVICES

Section 201(a) of the bill amends section 501 of the Social Security Act to increase the authorization of appropriations for grants to the States for maternal and child health services under part 1 of title V of such Act to $45 million for the fiscal year ending June 30, 1966; $50 million for the fiscal year ending June 30, 1967; $55 million each for the fiscal years ending June 30, 1968 and 1969; and $60 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter. Under existing law the authorized appropriation is $40 million each for the fiscal years ending June 30, 1966 and 1967, $45 million each for the fiscal years ending June 30, 1968 and 1969, and $50 million for the fiscal year ending June 30, 1970, and for each year thereafter.

Section 201(b) of the bill amends section 504 of the Act by adding a new subsection (d) which makes payments to States after June 30, 1966, contingent upon a satisfactory showing that the State is extending the provision of maternal and child health services in the State with a view to making such services available to children in all parts of the State by July 1, 1975.

SECTION 202. INCREASE IN CRIPPLED CHILDREN'S SERVICES

Section 202(a) of the bill amends section 511 of the Social Security Act to increase the authorization of appropriations for grants to the States for crippled children's services under part 2 of title V of such Act to $45 million for the fiscal year ending June 30, 1966; $50 million for the fiscal year ending June 30, 1967; $55 million each for the fiscal years ending June 30, 1968 and 1969; and $60 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter. Under existing law the authorized appropriation is $40 million each for the fiscal years ending June 30, 1966 and 1967, $45 million for the fiscal years ending June 30, 1968 and 1969, and $50 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

Section 202(b) of the bill amends section 514 of the Act by adding a new subsection (d) which makes payments to States after June 30, 1966, contingent upon a satisfactory showing that the State is extending the provision of crippled children's services in the State with a view to making such services available to children in all parts of the State by July 1, 1975.

SECTION 203. TRAINING OF PROFESSIONAL PERSONNEL FOR THE CARE OF CRIPPLED CHILDREN

Section 203 of the bill amends part 2 of title V of the Social Security Act by adding a new section 516 which authorizes grants to public or other nonprofit institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps. Authorizations for appropriations are $5 million for the fiscal year ending June 30, 1967, $10 million for the fiscal year ending June 30, 1968, and $17.5 million for each fiscal year thereafter.

SECTION 204. PAYMENT FOR INPATIENT HOSPITAL SERVICES

Section 204(a) of the bill amends section 503(a) of the Social Security Act to require a State plan for maternal and child health services to provide, effective July 1, 1967, for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan.

Section 204(b) of the bill amends section 513(a) of the Act to require a State plan for services for crippled children to provide, effective July 1, 1967, for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan.

SECTION 205. SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

Section 205 of the bill amends part 4 of title V of the Social Security Act by inserting a new section to provide special project grants to promote the health of school and preschool children. In conforming changes the heading of part 4 is revised accordingly and section 532 is redesignated section 533.

The new section 532(a) authorizes appropriations of $15 million for the fiscal year ending June 30, 1966, $35 million for the fiscal year ending June 30, 1967, $40 million for the fiscal year ending June 30, 1968, $45 million for the fiscal year ending June 30, 1969, and $50 million for the fiscal year ending June 30, 1970, for special project grants in order to promote the health of children and youth of school and preschool age, particularly in areas with concentrations of low income families. Section 532(b) authorizes the Secretary to make grants to a State health agency and (with the consent of such agency) to the health agency of any political subdivision of the State, to the State agency administering or supervising the administration of the crippled children's program under part 2q title V of the Social Security Act, to any school of medicine (with appropriate participation by a school of dentistry), and to any teaching hospital affiliated with such a school, to pay not to exceed 75 percent of the cost of projects of a comprehensive nature for health care and services for children and youth of school age or for preschool children (to help them prepare to start school). Projects for children and youth of school

age must include such screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, both medical and dental, as may be provided for in regulations of the Secretary. Treatment, correction of defects, and aftercare are to be available under the projects only to children who would not otherwise receive them because they are from low income families or for other reasons beyond their control. Projects must provide for coordination of the health care and services provided under them with, and for utilization of, other State or local health, welfare, and education programs for children, and for payment of the reasonable cost of inpatient hospital services.

The new section 532(c) provides for payment of the grants under section 532 in advance or by way of reimbursement, in such installments and on such conditions as the Secretary determines.

SECTION 206. EVALUATION AND REPORT

Section 206 of the bill requires the Secretary to submit to the President for transmission to the Congress before July 1, 1969, a full report of the administration of section 532 of the Social Security Act (special project grants for health of school and preschool children) together with an evaluation of the program and recommendations as to continuation of and modifications in the program.

Part 2. Implementation of Mental Retardation Planning

SECTION 211. AUTHORIZATION OF APPROPRIATIONS

Section 211(a) of the bill amends section 1701 of the Social Security Act to authorize appropriations for assisting States in initiating the implementation and carrying out of planning and other steps to combat mental retardation. The amounts authorized to be appropriated are $2,750,000 for the fiscal year ending June 30, 1966, and $2,750,000 for the fiscal year ending June 30, 1967.

Section 211(b) of the bill amends section 1702 of the act to provide that the sums appropriated pursuant to section 1701 for the fiscal year ending June 30, 1966, are to be available for grants during that fiscal year and the 2 immediately succeeding fiscal years, and that the sums appropriated for the fiscal year ending June 30, 1967, are to be available for such grants during that fiscal year and the immediately succeeding fiscal year.

Part 3—Public Assistance Amendments Relating to Health Care

SECTION 221. REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DISEASE

Paragraphs (1) and (2) of section 221(a) of the bill, and paragraphs (1) and (2) of section 221(d), amend the definitions of the terms "old-age assistance", "aid to the aged, blind, or disabled" (insofar

as it relates to the aged), and "medical assistance for the aged", as those terms appear in titles I and XVI of the Social Security Act. These amendments remove the limitations on Federal participation in aid or assistance to aged individuals who are patients in institutions for tuberculosis or mental diseases or who are patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis.

Section 221 (b) and (c) of the bill, and paragraph (1) of section 221(d), amend the definitions of the terms "aid to the blind", "aid to the permanently and totally disabled", and "aid to the aged, blind, or disabled" (insofar as it relates to the blind or disabled), as those terms appear in titles X, XIV and XVI, respectively, of the Social Security Act so as to remove the existing limitations in those titles on Federal sharing in aid to individuals who are patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis. Federal financial participation would remain unavailable with respect to payments to or care in behalf of blind or disabled individuals who are patients in an institution for tuberculosis or mental diseases under such titles X and XIV, and under such title XVI in the case of individuals under age 65.

Paragraph (3) of section 221(a) of the bill, and paragraph (3) of section 221(d), amend sections 2(a) and 1602(a), respectively, of the Social Security Act to add new plan requirements for a State which elects to include assistance in its State plan under title I (or aid or assistance in its State plan under title XVI, insofar as such aid relates to the aged) to or in behalf of individuals who are patients in tuberculosis or mental institutions. Such plan requirements are the same as those set forth in section 1902(a) (20) and (21) of title XIX as added to the Social Security Act by section 121(a) of the bill.

Paragraph (4) of section 221(a) of the bill, and paragraph (4) of section 221(d), add provisions to sections 3 and 1603, respectively, of the Social Security Act comparable to the provision set forth in section 1903(b) of title XIX (as added by section 121(a) of the bill). These provisions make the Federal share in State expenditures with respect to aged patients in institutions for tuberculosis or mental diseases contingent upon a comparable increase in total expenditures in the State for mental health services.

Section 221(e) of the bill provides that the amendments made by the preceding provisions of section 221 will apply to expenditures made after December 31, 1965, under a State plan approved under title I, X, XIV, or XVI of the Social Security Act.

SECTION 222. AMENDMENT TO DEFINITION OF MEDICAL ASSISTANCE FOR THE AGED

Sections 222(a) and 222(b) of the bill amend sections 6(b) and 1605(b), respectively, of the Social Security Act, to permit Federal sharing in State expenditures for medical assistance for the aged in the case of individuals who also received old-age assistance or aid to the aged, blind, or disabled in the month of their admittance to or discharge from a medical institution.

Section 222(c) of the bill provides that these amendments will apply to expenditures under a State plan approved under title I or XVI of the act with respect to care and services provided under such plan after June 1965.

TITLE III—SOCIAL SECURITY AMENDMENTS

Section 300 of the bill provides that title III of the bill may be cited as the "Old-Age, Survivors, and Disability Insurance Amendments of 1965".

SECTION 301. INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

Section 301 of the bill provides for a revised benefit table to effectuate a 7-percent benefit increase and new maximum benefit amounts.

Primary insurance amount

Section 301(a) of the bill amends section 215 of the Social Security Act to substitute for the present benefit table a new table. The new table effectuates the increase for people who were on the benefit rolls in any month after December 1964 and provides benefit amounts higher than those under present law for people who come on the benefit rolls in and after the month in which the bill is enacted. The new primary insurance amounts, shown in column IV of the table, represent an increase of 7 percent in the primary insurance amounts, with a minimum increase of $4, over the primary insurance amounts provided in present law, for average monthly wages up to and including $400 a month. (The primary insurance amount is the amount payable to a worker who retires at or after age 65 or to a disabled worker, and it is also the amount from which all other benefits are determined.)

An approximation of the benefits shown in the new benefit table can be arrived at by taking 62.97 percent of the first $110 of the average monthly wage, plus 22.9 percent of the next $290, plus 21.4 percent of the next $66. Benefits in the present table approximate 58.85 percent of the first $110 of average wage plus 21.4 percent of the next $290.

The primary insurance amounts provided by the revised table range from a minimum of $44 for people whose average monthly wage is $67 or less to a maximum of $149.90 for people who have the average monthly wage of $466 that will become possible in the future with the $5,600 contribution and benefit base which the bill (in sec. 320) provides. The primary insurance amounts of retired workers who are now on the benefit rolls is raised from $40 to $44 at the minimum and from $127 to $135.90 at the maximum.

Under the revised benefit table, the total monthly amount of benefits payable to a family on the basis of a single earnings record will be determined on the basis of a new formula. The maximum family benefit in present law (shown in column V of the benefit table) is the smaller of 80 percent of the average monthly wage or $254—twice the maximum primary insurance amount of $127—but it does not operate to reduce the family benefits to less than 1½ times the primary insurance amount. The $254 amount applies over a rather wide range of average monthly wage levels, so that the maximum family benefit is not wage-related at average monthly wage levels above $317. The formula used to determine the new maximum family benefit amounts (these amounts are shown in column V of the benefit table in the bill) is 80 percent of the average monthly wage up to the point at which the average monthly wage amount is two-thirds of the maximum possible average

monthly wage specified in the law, plus 40 percent of the remainder of the average monthly wage. This formula produces, at the maximum average monthly wage, a maximum family benefit of two-thirds of the average monthly wage. Specifically, with the $5,600 contribution and benefit base, the 40-percent part of the formula would begin to operate above the $314 average monthly wage level, which is about two-thirds of the maximum average monthly wage of $466 (more precisely, it is the top of the average-monthly-wage bracket that includes the amount that is two-thirds of $466). As under present law, the maximum will not operate to reduce family benefits below 1½ times the primary insurance amount. (Because this new formula for determining the maximum family benefits would result in lower family benefits ($253.20) than are provided under present law for average monthly wages in the range $315 to $319, the present $254 maximum is retained for this range in the new table.)

Primary insurance amount under 1958 act, as modified

Section 301(b) of the bill amends section 215(c) of the act to provide that a person who became entitled to old-age or disability insurance benefits before the date of enactment of the bill, or who died before such date, will have his primary insurance amount, as determined under the provisions of present law and appearing in column II of the revised table, converted to the higher primary insurance amount appearing on the same line in column IV of the new table. Under present law, column II shows the primary amounts in effect prior to the Social Security Amendments of 1958 and column IV of the table shows the amounts to which the primary insurance amounts in column II were converted as a result of those amendments.

Maximum benefits for people already on the rolls

Section 301(c) of the bill amends section 203(a)(2) of the act to assure an increase in the family benefits for families who were on the benefit rolls after December 1964 and whose benefits were determined under the provisions of the law in effect prior to the enactment of the bill. In the absence of such a provision some families now on the benefit rolls could receive little or no increase in benefits, since their benefits are already at or near the maximum amount that would be payable to the family. The bill provides that the maximum family benefit for each month after December 1964 will be the larger of (1) the family maximum specified in column V of the new table or (2) the sum of all family members' benefits after each such benefit has been increased by 7 percent (and rounded to the next higher 10 cents if it is not already a multiple of 10 cents). The section also repeals section 203(a)(3) of the act, which is a special saving clause for the maximum family benefits of people who became disabled before 1959. This clause is no longer needed since families whose benefits were determinded under this clause are now covered by paragraph (2) of section 203(a) as amended by the bill.

Effective date

Section 301(d) of the bill provides that the benefit increases provided for by subsections (a), (b), and (c) of section 301 will be effective for monthly benefits for months after December 1964 and for lump-sum death payments where death occurs in or after the month of enactment of the bill.

Special provision for conversion of a disability insurance benefit to an old-age insurance benefit

Section 301(e) of the bill is a special transitional provision which applies to an individual who was entitled to a disability insurance benefit for December 1964 and who became entitled to old-age insurance benefits in January 1965, to make certain that his primary insurance amount is increased. The general rule, provided in section 215(a)(4) of present law, that would apply in this situation is that an individual who was entitled to a disability insurance benefit for the month before he becomes entitled to an old-age insurance benefit will have as his primary insurance amount (and therefore his old-age insurance benefit) the amount in column IV of the table that is equal to his disability insurance benefit. In the situation outlined above, the individual's disability insurance benefit, since it was derived from a primary insurance amount determined under present law, does not have any direct connection with column IV of the table, which contains the new benefit amounts; and thus the general rule cannot be applied to this individual. Therefore, section 301(e) of the bill provides that his primary insurance amount is the amount in column IV of the table on the same line as that on which, in column II, appears his present primary insurance amount. (This primary insurance amount in col. II is equal to his disability insurance benefit under present law.)

Additional primary insurance amounts effective in January 1971

Section 301(f) of the bill revises and extends the benefit table effective with monthly benefits payable for January 1971. The benefit table is extended to take account of average monthly wages up to $550, the maximum average monthly wage that will be possible under the $6,600 annual contribution and benefit base that will be effective for years after 1970. Under the extended table, additional primary insurance amounts are provided up to a maximum of $167.90, based on an average monthly wage of $550.

The maximum family benefits were revised and extended on the basis of the same formula that was used in arriving at the maximum family benefits in the table provided in section 301(a). As a result, increased family maximum amounts are provided for average monthly wages of $315 to $466 (the maximum average monthly wage under the $5,600 base), since with the increase in the base the point up to which the 80-percent part of the formula applies is raised from $314 to $370. Also, of course, higher maximum family benefits are provided for the average monthly wages above $466 that will be possible under the $6,600 base, up to a maximum of $368 for an average monthly wage of $550.

SECTION 302. COMPUTATION AND RECOMPUTATION OF BENEFITS

Section 302 of the bill provides for automatic recomputation of benefit amounts under title II of the Social Security Act to take account of earnings after entitlement to benefits, and makes technical changes in the provisions for computation of benefits to facilitate automatic recomputation.

Average monthly wage

Section 302(a)(1) of the bill amends subparagraph (C) of section 215(b)(2) of the act to exclude from an insured individual's computation base years (from which the years to be used in the benefit computation are chosen) the year in which he became entitled to benefits and to include in his computation base years (for purposes of survivors' benefits) the year in which he died. As a result of this change, an individual's computation base years are the calendar years occurring after 1950 (or after 1936, as provided in section 215(d)) and up to the year in which his first month of entitlement to a benefit occurs or the year after the year in which he dies.

Section 302(a)(2) amends section 215(b)(3) of the act to provide that the number of an individual's elapsed years (which determine the number of years to be used in the benefit computation) will be counted up to the year in which he reaches age 65 (age 62 for women) or dies whether or not he is fully insured in that year. Under present law, an individual's elapsed years are counted up to the year in which he is *both* fully insured and age 65 (62 for women). Since almost all insured individuals are now insured by the time they reach the required age, the deletion of the provision in present law results in a simplification of the computation provisions.

Section 302(a)(3) amends paragraphs (4) and (5) of section 215(b) of the act. Paragraph (4), as amended, makes the new provisions of section 215(b) applicable only in the case of an individual who dies or becomes entitled to benefits or to a benefit recomputation under section 215(f)(2), as amended by the bill, after December 1965. The requirement in present law that an individual have not less than six quarters of coverage after 1950 in order to have his average monthly wage determined entirely on his earnings after 1950 is omitted from the amended paragraph. Paragraph (5), as amended, preserves the present method of computing the average monthly wage for people who, after the bill is enacted and prior to 1966 (the effective date of automatic recomputation), become entitled to benefits or a recomputation of benefits.

Primary insurance benefit under 1939 act

Section 302(b) of the bill makes a minor conforming change and updates a reference in section 215(d) of the act, relating to computation of primary insurance benefits under the 1939 Social Security Act.

Certain wages and self-employment income not to be counted

Section 302(c) of the bill amends section 215(e) of the act by striking out paragraph (3), which provides for a recomputation, for self-employed people who operate on a fiscal-year basis, to include earnings in the year of entitlement that were not available for inclusion in the original computation. This provision will not be needed, since these earnings will be taken into account under the automatic recomputation provisions which will be provided under section 215(f) as amended by the bill.

Recomputation of benefits

Section 302(d)(1) of the bill amends section 215(f)(2) of the act by providing for annual automatic recomputation of benefits, beginning in 1966.

The recomputation will take into account any earnings the person had in or after the year in which he became entitled to benefits (under

present law, a recomputation to include earnings in a year after entitlement requires an application and is not available unless the person had earnings of more than $1,200 for the year). The bill would also delete the requirements in present law that the person have six quarters of coverage after 1950 in order to qualify for the recomputation. A recomputation under the amended section 215(f)(2) will be effective, in the case of a living beneficiary, with January of the year following the year in which the earnings were received, and in death cases it will be effective for survivors' benefits beginning with the month of death.

Section 302(d)(2) repeals paragraphs (3), (4), and (7) of section 215(f) of the act, thereby eliminating the provisions for a recomputation to include earnings in the year of entitlement to benefits or in the year in which an individual's benefits were recomputed on account of additional earnings, the provisions for a recomputation for the purpose of paying benefits to survivors of an individual who died after 1960 and who had been entitled to old-age insurance benefits, and the provision for recomputing at age 65 the benefits of an individual who became entitled to benefits before that age. All of these are replaced by the automatic recomputation provision.

Recomputation of disability insurance benefits

Section 302(e) of the bill amends section 223(a)(2) of the act so that the provisions for computing disability insurance benefits will conform with the changed provisions for computing old-age insurance benefits.

Effective dates and saving provisions

Section 302(f)(1) of the bill provides that the repeal of section 215(e)(3) of the act made by section 302(c) (pertaining to recomputations for certain self-employed people) will be effective for individuals who become entitled to benefits after 1965.

Section 302(f)(2) provides that in any case where an individual would, by filing an application prior to January 2, 1966, be entitled to have his benefit recomputed under the provisions of existing law, the individual will be deemed to have filed an application on the date of enactment of the bill or the earliest date of eligibility thereafter and prior to January 2, 1966. Thus anyone who would profit from a recomputation under the provisions of present law will have his benefit amount recomputed automatically as though he had filed an application for that recomputation. The new automatic recomputation provisions will take over for the future.

Section 302(f)(3) retains paragraphs (3) and (4) of section 215(f) of present law for the purpose of providing, for survivors' benefits, a recomputation of the primary insurance amount of an individual who was entitled to an old-age insurance benefit and who died after 1960 and before 1966 without having filed an application for a recomputation. The new recomputation provisions will apply to deaths occurring after 1965.

Section 302(f)(4) retains until 1966 section 215(f)(7) of the act, which provides for the automatic recomputation of benefits to take account of earnings a man who is receiving actuarially reduced benefits may have had after entitlement and through the year of death or attainment of age 65. After 1965, these recomputations will be made under the new automatic recomputation provisions.

Section 302(f)(5) provides that the amendments made by section 302(e) (relating to computations of disability insurance benefits) will apply to individuals who become entitled to disability insurance benefits after 1965.

Section 302(f)(6) retains the provisions for figuring the average monthly wage which were in effect prior to the Social Security Amendments of 1960 so that an individual who was eligible for old-age insurance benefits before 1961 but who became entitled to benefits or died after 1960 can have his average monthly wage figured over less than 5 years of earnings where such a computation will result in a higher primary insurance amount. (Generally, under the Social Security Amendments of 1960, at least 5 years have to be used in the computation of the average monthly wage.)

SECTION 303. DISABILITY INSURANCE BENEFITS

Under existing law, the term "disability" is defined as inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration.

Section 303(a) of the bill amends clause (A) of the first sentence of section 216(i)(1), and paragraph (2) of section 223(c), of the Social Security Act, by striking out in both provisions the requirement that the individual's impairment be one which can be expected to result in death or to be of long-continued and indefinite duration.

Paragraph (1) of section 303(b) of the bill amends (and recodifies) paragraph (2) of section 216(i) of the Social Security Act to provide that a period of disability will end with the second month after the month in which disability ceases (as under existing law) if the individual has been under a disability continuously at least 18 months, but that such period will end with the first month after such cessation where he has been under a disability for a continuous period of less than 18 months. The new paragraph (2) also eliminates the present requirement that the individual must be under a disability when his application for a period of disability is filed and substitutes instead the requirement that no application for a disability determination which is filed more than 12 months after the month in which a period of disability would end (as specified in this section) shall be accepted.

Paragraph (2) of section 303(b) of the bill makes conforming changes in section 216(i)(3) of the Act.

Paragraph (3) of section 303(b) of the bill amends paragraph (1) of section 223(a) of the Act to provide that an individual who is insured for disability insurance benefits (as determined under subsection 223(c)(1)), has not attained age 65, and has filed application for disability insurance benefits is entitled to a disability insurance benefit for each month in his disability payment period (a new term which is defined in sec. 223(d), added by sec. 303(c) of the bill). This amendment eliminates the requirement in present law that an individual must be under a disability when he files his application for disability insurance benefits. In view of the change in the definition of disability and the provision in present law granting 12 months retroactivity to applications, this amendment permits the payment of benefits in those cases of extended disability which terminated before an application was filed. Thus, benefits will be paid for months of

disability even though at the time of filing application the disability has ceased so long as such months of disability fall within the period of retroactivity of the application.

Paragraph (4) of section 303(b) of the bill amends section 223(c)(3)(A) of the Act to eliminate the requirement that the individual must be under a disability which continues until his application for disability insurance benefits is filed. This amendment conforms to the amendment made by section 303(b)(3) of the bill, which eliminates the need for the existence of disability at the time the application was filed.

Section 303(c) of the bill amends section 223 of the Social Security Act by adding a new subsection (d) which defines the term "disability payment period."

Paragraph (1) of the new subsection (d) provides that, for purposes of section 223, the term "disability payment period" means the period beginning with the last month of the individual's waiting period and ending with the month preceding whichever of the following months is the earliest: the month in which he dies, the month in which he attains age 65, or either the second month following the month in which his disability ceases if he has been under a disability for a continous period of less than 18 calendar months or the third month following the month in which his disability ceases if he has been under a disability continuously for at least 18 calendar months. Under the amendment, three substantive changes are made in existing law. One change permits entitlement to benefits to begin with the 6th month of the waiting period—1 month earlier than under present law under which entitlement to disability benefits cannot begin earlier than the first month after the waiting period. The second change is to provide for benefits only for 2 additional months (as against 3 additional months under present law)—the month in which the disability ceased and the subsequent month—where the disability lasted less than 18 months. Where the disability lasted at least 18 months present law is retained by providing an adjustment period of 3 months' benefits. The third change is to eliminate the requirement that a disability benefit terminates with the month before the first month for which the individual is entitled to old-age insurance benefits. This is a conforming change made necessary by section 304(a) of the bill under which a disability insurance benefit may be paid after the individual becomes entitled to old-age insurance benefits.

Paragraph (2) of the new subsection (d) provides that if an individual had a period of disability which lasted at least 18 calendar months and which ceased within the 60-month period preceding the first month of his waiting period and such individual applies for disability insurance benefits on the basis of a disability which, at the time of application, can be expected to last at least 12 months or to result in death, then for purposes of section 223 the term "disability payment period" includes each month in the waiting period with respect to which such application was filed.

Paragraphs (1), (2), and (3) of section 303(d) of the bill make conforming changes in sections 222(c)(5), 223(a)(2)(B), 223(b), and 202(j)(1) of the Social Security Act. Paragraph (3) further amends section 223(b) to take into account the amendment made by section 303(b)(3) of the bill, which eliminates the need for the individual to be

under a disability at the time application is filed. The paragraph also amends section 202(j)(1) of the act to make it clear that a disability benefit payable under section 223 will be reduced so as not to render erroneous benefits paid prior to the filing of an application for disability benefits. This is in conformity with the amendment made by section 304 of the bill under which a larger benefit can become payable for prior periods during which other benefits had already been paid.

Paragraph (1) of section 303(e) of the bill provides that the amendments made by subsection (a) (eliminating the requirement that the individual's impairment be one that is expected to be of long-continued and indefinite duration or to result in death), by paragraphs (3) and (4) of subsection (b) (relating to eligibility for disability insurance benefits), and by paragraph (3) of subsection (d) (relating to such eligibility after termination of a period of disability) of section 303 of the bill, and subparagraphs (B), (E), and (F) of section 216(i)(2) of the Social Security Act as amended by subsection (b)(1) of section 303 (relating to establishing periods of disability), will be effective with respect to applications under sections 223 and 216(i) of the Social Security Act filed in or after the month in which the bill is enacted, or with respect to applications filed before such month if the applicant has not died before such month and if either (1) notice of the final decision of the Secretary has not been given to the applicant before such month, or (2) such notice has been so given before such month but a civil action thereon is commenced (whether before, in, or after such month, under section 205(g) of the Social Security Act and the decision in such civil action has not become final before such month. However, no monthly insurance benefits under title II of the Social Security Act are to be payable or increased by reason of the amendments made by subsections (a) and (b) of section 303 of the bill for months before the second month after the month of enactment of the bill. Periods of disability as defined in section 216(i)(2) of the Social Security Act may be established on the basis of the modified definition of disability even though such periods commence before the enactment of the bill.

Paragraph (2) of section 303(e) of the bill provides that the new section 223(d)(1) of the Social Security Act (relating to disability payment periods) will be applicable in the case of applications for disability insurance benefits filed by individuals the last month of whose waiting period occurs after the month of enactment of the bill. Those individuals whose waiting periods begin before the enactment of the bill will obtain the benefit of this amendment if the 6th month of their waiting period comes no earlier than the month after the month of enactment. Subparagraph (C) of such section 223(d)(1) (relating to the month in which disability payment periods end) applies to individuals entitled to disability insurance benefits whose disability ceases in or after the second month after the month of enactment of the bill. Thus, the reduction from 3 months to 2 months in cases of disabilities lasting less than 18 months will not apply to any cases where the disability ceased before such second month.

Paragraph (3) of section 303(e) of the bill provides that the new section 223(d)(2) of the Social Security Act (relating to second disabilities), and the conforming amendments made by subsection (d) of the bill, will be effective with respect to applications for disability

insurance benefits and for a disability determination filed after the month of enactment of the bill.

Paragraph (4) of section 303(e) of the bill provides that section 216(i)(2)(D) of the Social Security Act as amended by subsection (b)(1) of the bill (relating to the termination of a period of disability) will be effective with respect to a disability (as defined in sec. 216(i) of the Social Security Act as amended by the bill) which ceases in or after the second month following the month of enactment of the bill.

SECTION 304. PAYMENT OF DISABILITY INSURANCE BENEFITS AFTER ENTITLEMENT TO OTHER MONTHLY INSURANCE BENEFITS

Section 304 of the bill provides that an individual under age 65 may become entitled to disability insurance benefits after having become entitled to old-age, wife's, husband's, widow's, widower's, or parent's insurance benefits; this is not possible under existing law.

Section 304(a) adds a new paragraph (4) to section 202(k) of the Social Security Act to provide that a worker who is simultaneously entitled to both an old-age insurance benefit and a disability insurance benefit for any month will be entitled to receive only the disability insurance benefit for that month.

Section 304(b) changes the heading of section 202(q) of the act (relating to actuarial reduction of benefits) to include a reference to the reduction of disability insurance benefits and widow's insurance benefits (a reference to the latter is required because of the provision for payment of reduced benefits to widows at age 60 which is added to the act by sec. 307 of the bill).

Section 304(c) of the bill adds a new paragraph (2) to section 202(q) of the act and renumbers the present paragraphs (2) through (7) as paragraphs (3) through (8). The new paragraph (2) provides that if an individual is entitled to a disability insurance benefit after having been entitled to a reduced old-age insurance benefit, the disability insurance benefit (determined under sec. 223) will be reduced by the amount by which the old-age insurance benefit would have been reduced if the worker had reached age 65 in the month in which he most recently became entitled to the disability insurance benefit. For example, if a man became entitled at exact age 62 to a reduced old-age insurance benefit of $80 (based on a primary insurance amount of $100) and became entitled at exact age 63 to a disability insurance benefit of $105 (determined under sec. 223 of the act), the disability insurance benefit would be reduced by $6.60 (one-third of $20.00), the amount by which the old-age insurance benefit would have been reduced if the man had reached age 65 at the time when he became disabled. The effect of this provision is to reduce the disability insurance benefit to take account of the number of months for which the man actually got a reduced old-age insurance benefit before he became disabled.

Section 304(d) of the bill changes section 202(q)(3)(B) of the act (which provides for reducing wife's or husband's benefits where the wife or husband is also entitled to old-age benefits) to make the provisions of subparagraph (B) inapplicable for months for which the individual is entitled to a disability insurance benefit as well as a wife's or husband's benefit.

Section 304(e) amends subparagraph (C) of paragraph (3) (as redesignated by the bill) of section 202(q) of the act to provide that where a person is entitled to both a disability insurance benefit and to a reduced wife's, husband's, or widow's insurance benefit, the wife's, husband's, or widow's benefit will be reduced by the sum of: (1) the amount by which the disability insurance benefit was reduced to take account of prior entitlement to a reduced old-age insurance benefit, and (2) the amount by which the wife's, husband's, or widow's benefit would be reduced if it were equal to the amount by which such benefit (prior to any reduction) exceeded the unreduced disability insurance benefit.

Section 304(f) of the bill adds two new subparagraphs (F) and (G) to the redesignated paragraph (3) of section 202(q) of the act to provide for reducing the disability insurance benefit of an individual who becomes entitled to the disability benefit after having become entitled to a widow's benefit which is reduced because it was taken before age 62.

Subparagraph (F) sets forth the method for reducing the disability insurance benefit of a woman who becomes entitled to that benefit *at or after attainment of age 62* and who is entitled for the same month to a reduced widow's benefit. The amount of the reduction in the disability insurance benefit is whichever of the following is larger: (1) the amount by which the disability insurance benefit had been reduced because of prior entitlement to a reduced old-age benefit at age 62 or later, or (2) a sum equal to the amount by which the widow's benefit which the woman was getting at age 62 was reduced plus the amount by which the disability insurance benefit would be reduced (because of prior entitlement to a reduced old-age insurance benefit) if the disability benefit were equal to the excess of the unreduced disability benefit over the unreduced widow's insurance benefit.

Subparagraph (G) sets forth the method for reducing the disability insurance benefit of a woman who becomes entitled to the disability benefit *before attainment of age 62* and after entitlement to a reduced widow's benefit. Her disability insurance benefit will be reduced by the amount by which her widow's benefit would have been reduced if she had attained age 62 in the first month for which she became entitled to the disability insurance benefit.

Section 304(g) of the bill makes a conforming change in section 202(q)(4)(A) (as redesignated by the bill) to apply, to a person who is entitled to a disability insurance benefit which is reduced because of prior entitlement to a reduced benefit, the present provisions which set forth the method for reducing increases in benefits which occur after the person has come on the rolls and before he reaches age 65.

Section 304(h) of the bill adds a new subparagraph (F) to paragraph (7) (as redesignated by the bill) of section 202(q) of the act to provide that, in determining the "adjusted reduction period" (that is, the number of months in the reduction period for which a reduced benefit was actually paid and for which the old-age insurance benefit will be reduced for future months) applicable to a reduced old-age insurance benefit, any month for which a disability insurance benefit was payable will be excluded.

Section 304(i) of the bill is a conforming change in the redesignated paragraph (8) of section 202(q) to apply to the reduced disability

insurance benefit the provision in existing law for reducing the amount of the reduction to the next lower multiple of 10 cents if it is not already a multiple of 10 cents.

Section 304(j) of the bill makes a technical conforming change in paragraph (2) of section 202(r) of the act (relating to the presumed filing of application by individuals eligible for old-age insurance benefits and for wife's or husband's insurance benefits).

Section 304(k) of the bill amends section 215(a)(4) of the act, which provides a method of determining the primary insurance amount of an individual entitled to a disability insurance benefit who dies, or becomes entitled to an old-age insurance benefit (in the case of a woman) or attains age 65 (in the case of a man). Under existing law the primary insurance amount in such cases is equal to the disability insurance benefit; this provision operates properly under existing law because the disability insurance benefit is never reduced and thus is always equal to the primary insurance amount. Under the bill, however, the disability insurance benefit may be reduced and therefore smaller than the primary insurance amount. Section 304(k) therefore provides that the primary insurance amount to be used in the case where a disability beneficiary dies or becomes entitled to old-age insurance benefits or attains age 65 shall be the primary insurance amount on which the disability insurance benefit was based rather than the amount of the disability insurance benefit itself.

Section 304(l) of the bill amends paragraph (2) of section 216(i) of the act to remove a reference to section 223(a)(3) which is repealed by section 304(n) of the bill.

Section 304(m) of the bill makes a conforming change in paragraph (2) of section 223(a) to take account of the reduction of the disability insurance benefit under the provisions of section 202(q) as amended by the bill.

Section 304(n) of the bill repeals paragraph (3) of section 223(a) of the act, thereby permitting an individual to become entitled to a disability insurance benefit after having become entitled to a widow's, widower's, parent's, old-age, wife's, or husband's insurance benefit.

Section 304(o) of the bill provides that the amendments made by section 304 are to apply with respect to monthly benefits for and after the second month following the month of enactment of the bill on the basis of applications in or after such month of enactment.

SECTION 305. DISABILITY INSURANCE TRUST FUND

Section 305(a) of the bill amends section 201(b)(1) of the Social Security Act to increase the percentage of taxable wages appropriated to the disability insurance trust fund (now one-half of 1 percent) to three-fourths of 1 percent, effective with respect to wages paid after 1965.

Section 305(b) of the bill amends section 201(b)(2) of the Social Security Act to increase the percentage of taxable self-employment income appropriated to the disability insurance trust fund (now three-eighths of 1 percent) to nine-sixteenths of 1 percent, effective with respect to taxable years beginning after 1965.

SECTION 306. PAYMENT OF CHILD'S INSURANCE BENEFITS AFTER ATTAINMENT OF AGE 18 IN CASE OF CHILD ATTENDING SCHOOL

Section 306(a) of the bill amends subparagraph (B) of section 202(d)(1) of the Social Security Act to provide for the payment of benefits to a child up to the age of 22 if he is attending school. The amended subparagraph (B) also contains language relating to a child who is over 18 but who is unmarried and under a disability which began before he attained age 18 which conforms to the revised definition of disability in section 223(c) of the Social Security Act as amended by section 303(a)(2) of the bill. A child will be considered to be under a disability if the disability began before he attained the age of 18 and lasted, or could be expected to last, for a continuous period of at least 6 calendar months or to result in his death.

Subsection (b)(1) of section 306 amends the first sentence of section 202(d)(1) of the Social Security Act (relating to the termination of child's benefits) by adding six new subparagraphs. The new subparagraphs (D) and (E) retain the provisions of existing law which terminate a child's benefit if he marries, dies, or is adopted (except for adoption by certain relatives) and provide in general for the termination of the child's benefits at attaining age 18 if he is no longer attending school and is not under a disability.

The new subparagraph (F) provides that benefits for a child who is not disabled and is a full-time student in the month in which he attains age 18 will terminate with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

The new subparagraph (G) provides that benefits for a child who becomes entitled to benefits after he attains age 18 and is not disabled will end with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

The new subparagraph (H) provides that if a child ceases to be under a disability which began before he attained age 18 and which lasted for a continuous period of at least 18 months, and the child either attains age 22 before the close of the third month following the month in which his disability ceases or is not a full-time student during that month, his benefits will terminate with the month before such third month. However, if the child's disability lasted less than 18 months, and he either attains age 22 before the close of the second month following the month in which his disability ceases or is not a full-time student in that month, his benefits will terminate with the month before such second month.

The new subparagraph (I) provides that if a child's disability ceases after he attains age 18 but before he attains age 22, and if he is a full-time student in the third month (or second month, if his disability lasted less than 18 months) thereafter, his benefits will terminate with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

Subsection (b)(2) of section 306 repeals a sentence which is no longer needed because it has been incorporated in the changes made by subsection (b)(1).

Subsection (b)(3) of section 306 adds two new paragraphs, (7) and (8), to section 202(d) of the act. The new paragraph (7) permits a child whose benefits are terminated after he attains age 18 to become reentitled to child's insurance benefits, on filing a new application, if he becomes a full-time student before age 22. Such reentitlement to benefits will end with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

The new paragraph (8) defines "full-time student" and "educational institution." A full-time student is an individual who is in full-time attendance at an educational institution; whether or not the student was in full-time attendance is to be determined by the Secretary in the light of the standards and practices of the school involved. Specifically excluded from the definition of "full-time student" is a person who is paid by his employer while attending school at the request (or pursuant to a requirement) of his employer. Benefits are payable for any period of 4 calendar months or less in which a person does not attend school if the person shows to the satisfaction of the Secretary that he intends to continue in full-time school attendance immediately after the end of the period, or if the person is in fact in full-time attendance immediately after the end of the period.

The definition of "educational institution" includes all public schools, colleges, and universities, and all private schools, colleges, and universities which are accredited by a State recognized or nationally recognized accrediting association. Also included are those nonaccredited schools, colleges, and universities whose credits are accepted, on transfer, by three accredited institutions on the same basis as if transferred from an accredited institution.

Subsection (c)(1) of section 306 of the bill adds a new subsection (s) to section 202 of the act. Paragraph (1) of the new subsection (s) prevents a wife, widow, or surviving divorced mother from getting benefits if the only child in her care is getting benefits solely because he is a student.

Paragraph (2) of the new subsection (s) revises the provisions of law which permit a person with a childhood disability to continue to get benefits when he marries another beneficiary, and which permit such a beneficiary to continue to get benefits when he marries a person with a childhood disability. Benefits are payable if the child was under a disability which began before he attained age 18 or had been under such a disability in the third month before the month in which such marriage occurred.

Paragraph (3) of the new subsection (s) retains the provision in existing law which permits a person entitled to benefits because of a childhood disability to become entitled to a higher spouse's benefit without meeting the generally applicable dependency requirement.

Subsections (c)(2) through (c)(13) of section 306 make conforming changes to incorporate references to the new subsection (s).

Subsections (c)(14) and (c)(15) of section 306 provide that the provisions of existing law which relate to withholding of benefits payable to a person with a childhood disability while an investigation of whether his disability still exists is being made or when he refuses to accept vocational rehabilitation services will not apply with respect to children over 18 who are attending school.

Subsection (d) of section 306 provides that the amendments made by that section will be effective for January 1965 and months thereafter on the basis of applications for benefits filed in or after the month of enactment of the bill. Where a child was already on the rolls in the month the bill is enacted no application will be required.

SECTION 307. REDUCED BENEFITS FOR WIDOWS AT AGE 60

Widow's insurance benefits payable beginning at age 60

Section 307(a)(1) of the bill amends section 202(e) of the Social Security Act to provide that a widow may become entitled at age 60 to benefits based on the earnings record of her deceased husband. Section 307(a)(2) of the bill, by providing for the application to the benefits of section 202(q), provides that the benefits payable to widows who claim them before age 62 will be reduced to take account of the longer period over which they will be paid. Under existing law, unreduced benefits equal to 82½ percent of the deceased husband's primary insurance amount are payable to a widow at or after age 62.

Reduction factors

Section 307(b)(1) of the bill amends section 202(q)(1) of the Social Security Act, governing the reduction of benefits payable to beneficiaries who elect to start getting them prior to attainment of age 65, to provide that widow's insurance benefits to which a woman is entitled for a month before she is 62 are reduced by five-ninths of 1 percent for each month in the reduction period (the months prior to attainment of age 62 for which she is entitled to a widow's benefit) and that benefits to which she is entitled for the month in which she attains age 62 and months thereafter are reduced by the same percentage for each month in the adjusted reduction period (the months prior to attainment of age 62 for which the widow has actually been paid a benefit). This is the same factor as that which applies to an old-age benefit which is payable prior to attainment of age 65. Under the amendment, the benefits provided for a widow before age 62 may be reduced for as many as 24 months. The reduction for a widow claiming her benefit at exactly age 60 would be 13⅓ percent; her benefit would be reduced from the 82½ percent of her husband's primary insurance amount which would be payable to her at age 62 to 71½ percent of such primary insurance amount. For a widow who gets reduced benefits, the amount of the reduction in benefits would be adjusted at age 62 (as it is now adjusted at age 65 for old-age, wife's, or husband's benefits) to take account of any months in which no benefit was paid.

Entitlement to benefits on own earnings record

Paragraphs (2) and (3) of section 307(b) of the bill amend section 202(q)(3) (as renumbered by the bill) of the act to provide that where a widow is entitled to a disability insurance benefit based on her own earnings when she becomes entitled to a reduced widow's benefit, the reduction in the widow's benefit applies only to the excess of the widow's benefit over the benefit payable on her own earnings record. Similar provision is made under existing law for a person who is entitled simultaneously to a reduced old-age benefit and a wife's or husband's benefit; for example, where a wife is entitled

to a benefit based on her own earnings for the month for which she first becomes entitled to a wife's benefit the reduction factor applies only to the amount by which the wife's benefit exceeds her own benefit.

Reduction in subsequent old-age insurance benefit

Section 307(b)(4) of the bill adds a new subparagraph (E) to section 202(q)(3) (as renumbered) of the act to provide a method for reducing the old-age insurance benefit of a widow who is entitled to reduced widow's benefits. The old-age benefit (whether the woman begins to get it before or after she reaches age 65) will be reduced to take account of the widow's benefits paid to her before age 62. The amount of the reduction in the old-age benefit is whichever of the following is larger: (1) the reduction which would have been made in the old-age benefit if no widow's benefit had been payable, or (2) the dollar amount of the reduction in the widow's benefit plus the amount resulting from applying to the amount by which the unreduced old-age benefit exceeds the unreduced widow's benefit the reduction factor which would have been applied to the unreduced old-age benefit if the woman had not been eligible for a reduced widow's benefit.

The operation of this provision may be illustrated by the following example: Assume that a woman upon reaching age 60 elects to start getting a widow's benefit and that the benefit is reduced from $50.40 (82½ percent of her husband's primary insurance amount) to $43.70—a $6.70 reduction (24 months times five-ninths of 1 percent, or 13⅓ percent of $50.40). Assume further that at age 64 she becomes entitled to an unreduced old-age benefit of $76. If no widow's benefit had been payable, the $76 benefit would have been reduced to $71—a $5.00 reduction (12 months times five-ninths of 1 percent, or 6⅔ percent of $76). Under the new section 202(q)(3)(E), the amount by which her unreduced old-age benefit exceeds her unreduced widow's benefit, or $25.60 (the $76 old-age benefit less the $50.40 widow's benefit), will be reduced to $23.90—a $1.70 reduction (6⅔ percent of $25.60). Since the sum of the amount of the reduction in her widow's benefit and the reduction in her excess old-age benefit—$8.40 ($6.70 plus $1.70)—is larger than the amount by which her old-age insurance benefit would have been reduced—$5.00—her old-age benefit must be reduced by the larger amount—$8.40—that is, from $76 to $67.60.

Reduction where widow has a child in her care

Section 307(b)(5) of the bill adds to section 202(q)(5) (as renumbered) of the act a new clause, (D), to provide that, regardless of the provisions for reducing the benefits of widows who claim them before age 62, in no case will a widow who had in her care a child entitled to child's benefits get less in benefits for months in which she had the child in her care than the amount of the mother's insurance benefit (75 percent of her husband's primary insurance amount). This could happen, for example, where a widow started getting widow's benefits at age 60 (71½ percent of her husband's primary insurance amount) and starting at age 61 a child entitled to benefits was placed in her care. This provision permits her benefit amount for any month in which she has a child in her care to be increased to 75 percent of her husband's primary insurance amount.

Reduction period

Section 307(b)(6) of the bill amends section 202(q)(6) (as renumbered) of the act to provide that, in the case of widow's insurance benefits, the "reduction period" will begin with the first month for which the woman is entitled to a reduced widow's benefit and will end with the month before the month in which she attains age 62. The number of months in the "reduction period" is the number that is multiplied by five-ninths of 1 percent to determine the reduction in the benefits.

Adjusted reduction period

Section 307(b)(7) of the bill amends section 202(q)(7) (as renumbered) of the act, which describes the months which will be eliminated from the "reduction period" in determining the "adjusted reduction period" for purposes of establishing the benefit amount payable for months beginning with the month after the reduction period, to provide that, in determining a widow's adjusted reduction period at age 62, months in which her reduced widow's benefit was increased because she had in her care a child of her deceased husband entitled to child's insurance benefits, months in which her benefit was withheld because she had earnings from work, and months beginning with the month the widow's benefit was terminated through the month prior to the widow's attainment of age 62, will not be counted. For example, if a widow elects to start getting benefits upon reaching age 60 her benefit amount will be reduced by five-ninths of 1 percent for each of the 24 months in the reduction period; if, starting at age 61, a child entitled to a benefit is placed in the widow's care and remains in her care for 6 months, her benefit amount will be adjusted at age 62 and, for future months, will be reduced by five-ninths of 1 percent for each of the 18 months in the adjusted reduction period.

Definitions

Section 307(b)(8) of the bill adds a new paragraph (9) to section 202(q) of the act. The new paragraph defines "retirement age", for purposes of the actuarial reduction provisions, as age 65 for old-age, wife's, or husband's insurance benefits and age 62 for widow's insurance benefits.

Effective date

Section 307(c) of the bill provides that reduced widow's insurance benefits will be payable beginning with the second month after the month of enactment of the bill on the basis of applications filed in or after the month of enactment.

SECTION 308. WIFE'S AND WIDOW'S BENEFITS FOR DIVORCED WOMEN

Section 308(a) of the bill amends section 202(b) (relating to the payment of wife's insurance benefits) of the Social Security Act to provide for the payment of wife's insurance benefits to a divorced wife who had not remarried and who met the following support requirements at the time her former husband became entitled to old-age or disability insurance benefits, or at the time his period of disability began: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions

from him (pursuant to a written agreement), or (3) there was in effect a court order for substantial contributions to her support from him. The amended section 202(b) also provides that a wife's benefits will not terminate if she has attained age 62 and is divorced after having been married for 20 years (benefits for a wife under age 62 with a child in her care would terminate if she was divorced, regardless of how long she had been married, since benefits are not provided for a young divorced wife with a child in her care until after the former husband's death). The amended section 202(b) also adds to the present provisions for terminating wife's benefits a provision for terminating a divorced wife's benefit if she marries someone other than the worker on whose earnings her benefit is based. For purposes of paying benefits to a divorced wife, a remarriage which ended in a divorce after less than 20 years would be deemed not to have occurred. (Benefits will not be payable under this provision, for deeming the marriage not to have occurred, for any month before whichever of the following is the latest: The month after the month in which the divorce occurs; the 12th month before the month in which these benefits are applied for; or the 2d month after the month of enactment of the bill.) Also, if a divorced wife married a person entitled to benefits as a widower, parent, or disabled child, her benefits (and her new husband's benefits) would not be terminated, and if she married a person getting old-age or disability insurance benefits, she would immediately become eligible for wife's benefits based on her new husband's wages and self-employment income.

Section 308(b)(1) amends section 202(e) (relating to the payment of widow's insurance benefits) of such act to provide for the payment of widow's insurance benefits to a surviving divorced wife who had not remarried and who met the following support requirements at the time her former husband died, at the time he became entitled to old-age or disability benefits, or at the beginning of a period of disability which ended with his death or entitlement to monthly benefits: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions from him (pursuant to a written agreement), or (3) there was in effect a court order for substantial contributions to her support from him.

Sections 308(b)(2) and 308(b)(3) of the bill make conforming changes in the provisions for paying widow's benefits to a surviving divorced wife so that she will have the same treatment as a widow has under existing law in the event that she marries a beneficiary or a person who dies within 1 year and is not insured.

Section 308(b)(4) of the bill further amends the existing provisions of section 202(e) of the act for paying widow's insurance benefits to provide that, for purposes of paying benefits to widows and surviving divorced wives, a remarriage which ends in divorce after less than 20 years will be deemed not to have occurred. (Benefits will not be payable under this provision, for deeming the marriage not to have occurred, for any month before whichever of the following is the latest: The month after the month in which the divorce occurs; the 12th month before the month in which these benefits are applied for; or the 2d month after the month of enactment of the bill.)

Section 308(c) amends section 216(d) of the Social Security Act to define "divorced wife", "surviving divorced wife", "surviving divorced mother", and "divorce". Paragraphs (1) and (2) of the new subsection (d) define "divorced wife" and "surviving divorced wife" as a

woman divorced from an individual to whom she was married for a period of 20 years immediately before the divorce. The new paragraph (3) of section 216(d) substitutes the term "surviving divorced mother" for the term "former wife divorced" in the definition of the latter term as contained in existing law. Paragraph (4) defines "divorce" and "divorced" as meaning a divorce *a vinculo matrimonii*. Existing law uses the full term wherever divorce is mentioned.

Section 308(d)(1) of the bill deletes a reference to "divorced *a vinculo matrimonii*" which is no longer needed because of the definition of divorce included in the law by section 308(c) of the bill.

Section 308(d)(2) amends the provisions of the Social Security Act for continuing child's, widower's, and parent's benefits if the beneficiary marries a person getting dependents' or survivors' benefits so that such benefits will not terminate if the beneficiary marries a divorced wife getting wife's benefits. Section 308(d)(2) also has the effect of providing that a woman getting benefits as a divorced wife who marries an old-age or disability insurance beneficiary may become eligible for wife's or widow's benefits on the basis of her new husband's wages and self-employment income without regard to the 1-year duration-of-marriage requirement in present law. (Similar treatment is provided for individuals entitled to widow's benefits under existing law.)

Paragraphs (3), (4), and (5) of section 308(d) amend section 202(g) (relating to mother's insurance benefits). Under the amendment made by paragraph (3), the support requirement which must be met if a surviving divorced mother is to qualify for mother's insurance benefits is the same as the new support requirement provided for a "divorced wife" and a "surviving divorced wife." Under the amendment made by paragraph (4), for purposes of paying mother's insurance benefits to a widow or surviving divorced mother, a subsequent marriage which ends in divorce after less than 20 years may be deemed not to have occurred. (Benefits will not be payable under this provision, for deeming the marriage not to have occurred, for any month before whichever of the following is the latest: The month after the month in which the divorce occurs; the 12th month before the month in which these benefits are applied for; or the 2d month after the month of enactment of the bill.) This provision does not preclude payment of mother's insurance benefits on the basis of the wages and self-employment income of a person to whom she was remarried for less than 20 years and from whom she had been divorced if she could become entitled to such benefits under existing law.

Paragraph (5) would replace the present term "former wife divorced" with the term "surviving divorced mother" in section 202(g) of existing law (relating to mother's insurance benefits).

Paragraph (6) of section 308(d) amends section 203(a) (relating to maximum family benefits) to provide that the monthly benefits paid to a divorced wife or a surviving divorced wife will not be reduced because of the limit on total family benefits and will not be counted in figuring the total benefits payable to others on the basis of the wages or self-employment income of the same individual.

Paragraphs (7), (8), (9), (10), and (11) of section 308(d) make conforming changes in various sections of the Social Security Act.

Section 308(e) of the bill provides an effective date for the section. Wife's and widow's insurance benefits for a divorced wife and a surviving divorced wife will be payable beginning with the second

month after the month of enactment of the bill, but, in the case of an individual who was not entitled to benefits in the month after the month of enactment, only on the basis of an application filed in or after the month of enactment.

SECTION 309. TRANSITIONAL INSURED STATUS

Section 309(a) of the bill adds a new section 227 at the end of title II of the Social Security Act (after the new section 226 added by section 101 of the bill) to provide a special insured status for certain individuals now in their seventies or over who are not eligible for benefits under the provisions of present law because they (or their husbands) do not have 6 quarters of coverage.

Subsection (a) of the new section 227 provides that anyone who attains age 72 before 1969 and does not meet the existing insured-status requirements of section 214(a) will nevertheless be insured if he has one quarter of coverage for each year elapsing after 1950 and before the year in which he attained retirement age (65 for men, 62 for women) and if he has not less than 3 quarters of coverage. These provisions will merge gradually into the fully-insured-status provisions of the present law, so that men who attained age 65 and women who attained age 62 after 1956 will have to meet the requirements of present law in order to qualify for benefits. The following table sets forth the quarter-of-coverage requirements under this provision and shows how these requirements merge with the minimum 6 quarters of coverage required under present law:

Men		Women	
Age (in 1965)	Quarters of coverage required	Age (in 1965)	Quarters of coverage required
76 or over	3	73 or over	3.
75	4	72	4.
74	5	71	5.
73 or younger	6 or more (same as present law)	70 or younger	6 or more (same as present law).

The benefit payable to a person who meets only the transitional requirement will be $35. The wife of such a person, if she attains age 72 before 1969, will be eligible at age 72 for a wife's benefit of $17.50.

Subsection (b) of the new section 227 provides benefits for a widow who reaches age 72 before 1969 and whose husband died before 1957 or reached age 65 before 1957 and died before the transitional provisions go into effect. Such a widow could qualify for widow's benefits of $35 a month if the man had 3, 4, or 5 quarters of coverage, as shown in the following table (which also shows the requirements of present law):

Year of husband's death (or attainment of age 65, if earlier)	Quarters of coverage required under present law	Quarters of coverage required under the bill for a widow attaining age 72 in—		
		1966 or before	1967	1968
1954 or before	6	3	4	5.
1955	6	4	4	5.
1956	6	5	5	5.
1957 or after	6 or more	6 or more	6 or more	6 or more.

Subsection (c) of the new section 227 provides that a widow whose husband dies after the transitional provisions go into effect can become entitled to widow's benefits of $35 a month if she reaches age 72 before 1969, if her husband reached age 65 before 1957, and if he was (or, upon filing an application prior to his death, would have been) entitled to benefits under the transitional provisions.

Section 309(b) of the bill makes the transitional insured status provisions effective for monthly benefits beginning with the second month following the month of enactment of the bill on the basis of applications filed in or after the month of such enactment.

SECTION 310. INCREASE IN AMOUNT AN INDIVIDUAL IS PERMITTED TO EARN WITHOUT SUFFERING FULL DEDUCTIONS FROM BENEFITS

Section 310(a) of the bill amends paragraph (3) of section 203(f) of the Social Security Act by changing the provision in present law under which there is a $1-for-$2 reduction (i.e., a $1 reduction in benefits for each $2 of earnings) above $1,200 and up to $1,700 to provide instead for a $1-for-$2 reduction for earnings from $1,200 to $2,400. Benefits will continue to be reduced by $1 for each $1 of earnings above $2,400, as they are now for earnings above $1,700.

Section 310(b) of the bill provides that the change made by section 310(a) will be effective for taxable years ending after 1965.

SECTION 311. COVERAGE FOR DOCTORS OF MEDICINE

Amendments to Title II of the Social Security Act

Removal of exclusion for doctors of medicine

Under existing law, services performed by a self-employed person in the exercise of his profession as a doctor of medicine, or as a member of a partnership engaged in the practice of medicine, are excepted from the term "trade or business" and thus from self-employment coverage under section 211(c)(5) of the Social Security Act. Section 311(a)(1) of the bill amends section 211(c)(5) of the act by removing the exception provided for services performed as a doctor of medicine or as a member of a partnership engaged in the practice of medicine. In general, the effect of this amendment is to extend social security coverage to net earnings derived by an individual from the practice of medicine on his own account or by a partnership of which he is a member.

Section 311(a)(2) of the bill conforms the provisions of the last two sentences of section 211(c) of the act to the amendment made by section 311(a)(1) of the bill.

Removal of exclusion for interns in Federal hospitals

Section 210(a)(6)(C)(iv) of the Social Security Act excludes from the term "employment," and thus from social security coverage, services performed by certain interns, student nurses, and other student employees of hospitals of the Federal Government. Section 311(a)(3) of the bill amends section 210(a)(6)(C)(iv) of the act so as to remove the exclusion insofar as it pertains to medical or dental interns and medical or dental residents-in-training. The effect of this amendment

is to extend social security coverage to such individuals with respect to services performed by them as interns or residents-in-training in the employ of hospitals of the Federal Government.

Removal of exclusion for student interns

Section 210(a)(13) of the Social Security Act excludes from the term "employment," and thus from social security coverage, services performed as an intern in the employ of a hospital by an individual who has completed a 4-year course in a medical school chartered or approved pursuant to State law. Section 311(a)(4) of the bill amends section 210(a)(13) so as to remove this exclusion. The effect of this amendment is to extend social security coverage to such interns unless their services are excluded under provisions other than section 210(a)(13). Thus, the services of an intern are covered if he is employed by a hospital which is not exempt from income tax as an organization described in section 501(c)(3) of the code. If the intern is employed by a hospital which is exempt from income tax and which has a waiver certificate in effect under section 3121(k) of the code, he is not excluded from coverage by section 210(a)(8)(B) of the Social Security Act if coverage was effected under such certificate.

Amendments to the Internal Revenue Code of 1954

Removal of exclusion for doctors of medicine

Under existing law, services performed by a self-employed person in the exercise of his profession as a doctor of medicine, or as a member of a partnership engaged in the practice of medicine, are excepted from the term "trade or business" under section 1402(c)(5) of the Internal Revenue Code of 1954. Section 311(b)(1) of the bill amends section 1402(c)(5) of the code by removing the exception provided for services performed as a doctor of medicine or as a member of a partnership engaged in the practice of medicine. In general, the effect of this amendment is to subject the net earnings derived by an individual from the practice of medicine on his own account or by a partnership of which he is a member to the self-employment tax.

Section 311(b)(2) of the bill conforms the provisions of the last two sentences of section 1402(c) of the code to the amendment made by section 311(b)(1).

Technical amendments

Section 311(b)(3) of the bill conforms the language of sections 1402(e)(1) and 1402(e)(2) of the code to the amendment made by section 311(b)(1).

Removal of exclusion for interns in Federal hospitals

Section 3121(b)(6)(C)(iv) of the Internal Revenue Code of 1954 excludes from the term "employment," and thus from coverage under the Federal Insurance Contributions Act, services performed by certain interns, student nurses, and other student employees of hospitals of the Federal Government. Section 311(b)(4) of the bill amends section 3121(b)(6)(C)(iv) of the code so as to remove the exclusion insofar as it pertains to medical or dental interns and medical or dental residents-in-training. The effect of this amendment is to make the remuneration of such individuals for services performed by them as such interns or residents-in-training in the employ of hospitals

of the Federal Government subject to the Federal Insurance Contributions Act.

Removal of exclusion for student interns

Section 3121(b)(13) of the Internal Revenue Code of 1954 excludes from the term "employment," and thus from coverage under the Federal Insurance Contributions Act, services performed as an intern in the employ of a hospital by an individual who has completed a 4-year course in a medical school chartered or approved pursuant to State law. Section 311(b)(5) of the bill amends section 3121(b)(13) so as to remove this exclusion. The effect of this amendment is to extend coverage under the Federal Insurance Contributions Act to such interns unless their services are excluded under provisions other than section 3121 (b)(13). Thus, the services of an intern are covered if he is employed by a hospital which is not exempt from income tax as an organization described in section 501(c)(3) of the code. If the intern is employed by a hospital which is exempt from income tax and which has a waiver certificate in effect under section 3121(k) of the code, he is not excluded from coverage by section 3121(b)(8)(B) of the code if coverage was effected under such certificate.

Effective Date

Section 311(c) of the bill provides that the amendments made by paragraphs (1) and (2) of section 311(a) and by paragraphs (1), (2), and (3) of section 311(b), relating to the self-employment coverage of doctors of medicine, are effective for taxable years ending after December 31, 1965. The amendments made by paragraphs (3) and (4) of section 311(a) and by paragraphs (4) and (5) of section 311(b), relating to social security coverage of interns and residents-in-training, are effective with respect to services performed after 1965.

SECTION 312. GROSS INCOME OF FARMERS

Increasing gross income taken into account for optional method of computing net earnings from farm self-employment; amendments to title II of the Social Security Act

Section 312(a) of the bill amends section 211(a) of the Social Security Act to increase from $1,800 to $2,400 the maximum gross income from agricultural activity that a self-employed farmer may use under the optional method of computing his net earnings from self-employment as a farmer. Under present law, an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $1,800 or less may, at his option, base his self-employment coverage on two-thirds of his gross income from farming; if such individual's gross income is more than $1,800 and his net earnings from self-employment as a farmer are less than $1,200, he may report $1,200 as net earnings from self-employment; if his net earnings from self-employment as a farmer are $1,200 or more, he must report his actual net earnings from self-employment as a farmer. Under the amendments made by section 312(a) of the bill an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $2,400 or less may, at his option, base his self-employ-

ment coverage on two-thirds of his gross income from farming; if he has gross income of more than $2,400 and net earnings from self-employment of less than $1,600, he may report $1,600 as net earnings from self-employment as a farmer; if his net earnings from self-employment as a farmer are $1,600 or more, he must report his actual net earnings from self-employment as a farmer.

Same: Amendments to the Internal Revenue Code of 1954

Section 312(b) of the bill amends section 1402(a) of the Internal Revenue Code of 1954 to increase from $1,800 to $2,400 the maximum gross income from agricultural activity that a self-employed farmer may use under the optional method of computing his net earnings from self-employment as a farmer. Under present law, an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $1,800 or less may, at his option, treat as net earnings from such self-employment two-thirds of his gross income from farming; if such individual's gross income is more than $1,800 and his net earnings from self-employment as a farmer are less than $1,200, he may treat $1,200 as net earnings from self-employment; if his net earnings from self-employment as a farmer are $1,200 or more, he must report his actual net earnings from self-employment as a farmer. Under the amendments made by section 312(b), an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $2,400 or less may, at his option, treat as net earnings from such self-employment two-thirds of his gross income from farming; if he has gross income from farming of more than $2,400 and his net earnings from self-employment as a farmer are less than $1,600, he may report $1,600 as net earnings from self-employment as a farmer; if his net earnings from self-employment as a farmer are $1,600 or more, he must report his actual net earnings from such self-employment.

Effective Date

Section 312(c) of the bill provides that the amendments made by sections 312(a) and 312(b) will apply with respect to taxable years beginning after December 31, 1965.

SECTION 313. COVERAGE OF TIPS

Section 313 of the bill provides for treating tips received by an employee in the course of his employment as wages paid by the employer for social security tax and benefit purposes and for the purpose of withholding income tax at source. The provisions of this section have no application to amounts which under existing law constitute wages.

Amendments to Title II of the Social Security Act

Section 313(a)(1) of the bill amends section 209 of the Social Security Act (defining "wages" for social security benefit purposes) by adding a new subsection (l). The new subsection provides that tips do not constitute wages if they are paid in a medium other than cash or if the cash tips received in a calendar month by the employee in the course of his employment by a single employer amount to less than $20.

Section 313(a)(2) of the bill further amends section 209 of the act by adding a new unnumbered paragraph at the end thereof. The new paragraph provides that tips received by an employee in the course of his employment (which are not excluded from wages under the new sec. 209(l) of the act) are to be considered wages for social security benefit purposes. Such tips are deemed paid to the employee by the employer and are deemed so paid at the time a written statement including such tips is furnished the employer pursuant to section 6053(a) of the Internal Revenue Code of 1954 (added by sec. 313(e) (2) of the bill). Tips not included in a written statement or included in a written statement not furnished the employer by the close of the 10th day following the month of receipt (as prescribed in sec. 6053(a) of the code) are considered to have been paid to the employee at the time the tips are received. Tips constitute wages for social security benefit purposes regardless of whether the tips are received by the employee from a person other than his employer or are paid to the employee by his employer. Only tips received by an employee on his own behalf and not on behalf of another employee constitute wages. Thus, where employees practice tip splitting, the ultimate recipient of the tip (or portion thereof) is the employee who is receiving the tip as wages.

Amendments to the Internal Revenue Code of 1954

Section 313(b) of the bill amends section 451 of the Internal Revenue Code of 1954 (relating to the general rule for determining the taxable year of inclusion of an item in gross income) by adding a new subsection (c). The new subsection provides that for purposes of determining the taxable year for which tips are to be included in gross income for income tax purposes, tips included by an employee in a written statement furnished to his employer in the manner and within the time prescribed in section 6053(a) are deemed received by the employee at the time the statement is furnished. Tips not included in a written statement or included in a written statement which is not furnished as prescribed in section 6053(a) are not affected by this subsection; such tips will continue to be treated as received when actually received but in accordance with the general rule provided in section 451(a).

Section 313(c)(1) of the bill amends section 3102 of the code (relating to deduction by the employer of the employee's social security tax from the employee's wages) by adding a new subsection (c).

Under paragraph (1) of the new subsection (c) the employer is responsible for deducting the employee's social security tax on tips, which constitute wages for social security tax purposes, but only to the extent that such tips are included in a written statement furnished the employer pursuant to section 6053(a), and only to the extent that, at or after the time the statement is furnished and before the close of the 10th day following the month in which the tips were received (the last day on which such a statement could be furnished under sec. 6053(a)), the employer can collect the employee's share of the tax by deducting it from wages (not including tips) of the employee under the employer's control, or from funds turned over to him for that purpose by the employee.

Paragraph (2) of the new subsection (c) provides that if the employee's share of social security tax due on tips included in a written

statement furnished to the employer pursuant to section 6053(a) exceeds the wages (other than tips) of the employee already under the employer's control, the employee must give the employer on or before the 10th day following the month in which the tips are received, an amount of money which when added to the wages under the employer's control will be sufficient to pay the tax.

Paragraph (3) of the new subsection (c) authorizes the Secretary of the Treasury or his delegate to prescribe regulations permitting an employer to (1) estimate the amount of tips an employee will report to him pursuant to section 6053 of the code (added by sec. 313(e)(2) of the bill) for a calendar quarter; (2) determine the amount to be deducted upon each payment of wages (other than tips) during such quarter as if the tips so estimated constituted the actual tips so reported; and (3) deduct upon any payment of wages (other than tips) to such employee during such quarter such amount as may be necessary to adjust the amount of tax withheld to conform to the amount actually due during the quarter (determined without regard to the new paragraph (3)).

Section 313(c)(2) of the bill further amends section 3102 of the code to authorize an employer who is furnished a written statement of tips to withhold the employee social security tax on the tips included in the statement even though at the time it is furnished the total amount of tips included in the statement and prior written statements for the month is less than $20.

Section 313(c)(3) of the bill amends section 3121(a) of the code (defining "wages" for social security tax purposes) by adding a new paragraph (12). The new paragraph provides that tips do not constitute wages for social security tax purposes if they are paid in a medium other than cash or if the cash tips received in a calendar month by the employee in the course of his employment by a single employer amount to less than $20.

Section 313(c)(4) of the bill further amends section 3121 of the code by adding a new subsection (q). The new subsection provides that tips received by an employee in the course of his employment (which are not excluded from wages under the new par. (12) of sec. 3121(a)) are to be considered wages, and thus subject to the social security tax. Such tips are deemed paid to the employee by the employer at the time a written statement including such tips is furnished the employer pursuant to section 6053(a). Tips not included in a written statement or included in a written statement not furnished the employer by the close of the 10th day following the month of receipt (as prescribed in sec. 6053(a)) are considered to have been paid to the employee at the time the tips are received. Tips constitute wages for social security tax purposes regardless of whether the tips are received by the employee from a person other than his employer or are paid to the employee by his employer. Only tips received by an employee on his own behalf and not on behalf of another employee constitute wages. Thus, where employees practice tip splitting, the ultimate recipient of the tip (or portion thereof) is the employee who is receiving the tips as wages.

Section 313(d)(1) of the bill amends section 3401 of the code (defining "wages" subject to income tax withholding) by adding a new subsection (f). The new subsection provides that tips received by an employee in the course of his employment, subject to the

exceptions in section 3401(a)(16) of the code (added by sec. 313(d)(2) of the bill), are to be considered wages, and thus subject to withholding of income tax at source. Such tips are deemed paid by the employer to the employee at the time a written statement including such tips is furnished the employer pursuant to section 6053(a). Tips not included in a written statement or included in a written statement furnished to the employer after the time prescribed in section 6053(a) are considered to have been paid to the employee at the time the tips are received. Tips constitute wages for income tax withholding purposes regardless of whether the tips are received by the employee from a person other than his employer or are paid to the employee by his employer. Only tips received by an employee on his own behalf and not on behalf of another employee constitute wages. Thus, where employees practice tip splitting, the ultimate recipient of the tip (or portion thereof) is the employee who is receiving the tips as wages.

Section 313(d)(2) of the bill further amends section 3401 of the code by adding a new paragraph (16) to subsection (a) thereof. The new paragraph provides that tips do not constitute wages subject to income tax withholding if they are paid in a medium other than cash or if the cash tips received in a calendar month by the employee in the course of his employment by a single employer amount to less than $20.

Section 313(d)(3) of the bill amends section 3402(a) of the code (relating to determining the amount of income taxes the employer is to withhold on wages) by making appropriate reference to new section 3402(k), relative to tips, added by section 313(d)(4) of the bill.

Section 313(d)(4) further amends section 3402 of the code by adding a new subsection (k). The new subsection specifies that the employer is responsible for withholding income tax on tips which constitutes wages for income-tax withholding purposes but only if the tips are included in a written statement furnished the employer pursuant to section 6053(a), and only to the extent that, at or after the time the statement is furnished and before the close of the calendar year in which the tips are received, the employer can collect the tax by deducting it from wages (not including tips) of the employee under the employer's control, or from funds turned over to him for that purpose by the employee, remaining after the employee social security tax has been subtracted. Also, the new subsection authorizes an employer who is furnished a written statement of tips pursuant to section 6053(a) to withhold income taxes on the tips included in such statement, even though at the time it is furnished the total amount of tips included in that statement and prior written statements for the month is less than $20.

Section 313(e)(1) of the bill amends section 6051(a) of the code (relating to amounts to be shown as "wages" on employee receipts—currently form W–2) by adding a new sentence which provides (1) that the amount to be shown on an employee's receipt as wages subject to social security tax will include tips only to the extent they are included in one or more written statements furnished the employer before the close of the 10th day following the month in which the tips are received, pursuant to section 6053(a), and only to the extent that, at or after the time the statement is furnished and before the close of the last day on which such a statement could be furnished

under section 6053(a), the employer can collect the employee's social security tax from wages (not including tips) of the employee under the employer's control or from funds turned over to the employer by the employee for that purpose; and (2) that the amount to be shown as wages subject to income tax will include tips only to the extent they are included in a timely written statement furnished the employer pursuant to section 6053(a) of the code, irrespective of whether or not the employer was able to deduct and withhold the income tax before the close of the calendar year.

Section 313(e)(2) of the bill amends subpart C of part III of subchapter A of chapter 61 of the code (relating to the information regarding wages paid employees) by adding a new section 6053.

Subsection (a) of the new section 6053 requires every employee who receives tips which constitute wages for social security tax purposes or income tax withholding purposes to furnish to his employer, in accordance with regulations prescribed by the Secretary of the Treasury or his delegate, one or more written statements of his tips before the close of the 10th day following the month in which the tips were received. The Secretary of the Treasury is authorized to prescribe regulations under which employers may require employees to furnish statements more frequently than once a month. He may also prescribe the form in which the employee statements of tips will be made to the employer.

Subsection (b) of the new section 6053 provides that the tips to be taken into consideration—

> (1) for purposes of the employer's obligation to collect the employee's share of the tax, pay the employer's share of the tax, and show the wages as being subject to social security tax on an employees' receipt (form W–2), and
>
> (2) for purposes of imposing the penalty, provided by new section 6652(c) of the code (added by sec. 313(e)(3) of the bill), on an employee for failure to report tips and make available his share of the social security tax due on such tips,

are only those tips which are included in a statement furnished the employer pursuant to subsection (a) of section 6053 and only to the extent that, at or after the time the statement is furnished and before the close of the 10th day following the month in which the tips were received, the employer can collect the employee's share of the social security tax from the employee's wages (other than tips) or from other funds turned over by the employee for this purpose pursuant to section 3102(c).

Section 313(e)(3) of the bill amends section 6652 of the code (relating to failure to file certain information returns) by adding a new subsection (c). The new subsection provides that the employee will be required to pay, with respect to tips which he failed to include in a timely written statement to his employer pursuant to section 6053(a) or which he included in a timely written statement but did not make available his share of the social security tax pursuant to section 3102(c), both the employee tax imposed by section 3101 on such tips and an additional amount equal to the employee tax, unless it is shown that the employee's failure was due to reasonable cause and not due to willful neglect.

Section 313(f) of the bill amends section 3111 of the code (relating to the imposition of the social security tax on employers) by adding a

sentence to provide that the employer is liable for paying the employer social security tax only on those tips which are included in a timely written statement furnished him pursuant to section 6053(a), and on which, pursuant to section 3102(c), the employer can collect the employee social security tax, on or after the time the statement is furnished and before the close of the last day on which such a statement could be furnished under section 6053(a), from wages (not including tips) of the employee under the employer's control or from funds turned over to the employer by the employee for that purpose.

Section 313(g) of the bill provides that the amendments made by section 313 of the bill will be effective only with respect to tips received by employees after 1965.

SECTION 314. INCLUSION OF ALASKA AND KENTUCKY AMONG STATES PERMITTED TO DIVIDE THEIR RETIREMENT SYSTEMS

Section 314 of the bill amends section 218(d)(6)(C) of the Social Security Act by adding Alaska and Kentucky to the list of States which are permitted to divide their retirement systems into two divisions for coverage purposes, one division consisting of those members desiring coverage under the act and the other consisting of those who do not, with all new members being covered on a compulsory basis.

SECTION 315. ADDITIONAL PERIOD FOR ELECTING COVERAGE UNDER DIVIDED RETIREMENT SYSTEM

Section 315 of the bill amends section 218(d)(6)(F) of the Social Security Act to grant an additional opportunity to obtain coverage to State and local employees (in a State permitted to use the divided retirement system procedure) who had not previously chosen coverage under the divided retirement system provisions. The present law allows such employees a further opportunity to elect coverage only if a modification providing for such election is mailed or otherwise delivered to the Secretary before 1963, or, if later, 2 years after the date on which coverage was approved for the group that originally elected coverage. Any coverage elected after the original division must begin on the same date as was provided when the group was originally covered. Section 315 extends the time in which such persons could elect to be covered until the end of 1966 (or, if later, the expiration of 2 years after the date on which coverage was approved for the group that originally elected coverage).

SECTION 316. EMPLOYEES OF NONPROFIT ORGANIZATIONS

Section 316 of the bill amends section 3121(k) of the Internal Revenue Code of 1954 and section 105(b) of the Social Security Amendments of 1960.

Period for which certificate shall apply

Section 316(a)(1) of the bill amends section 3121(k)(1)(B) of the code, which relates to the period for which certificates filed by certain

religious, charitable, etc., organizations for the purpose of waiving exemption from tax under chapter 21 of such code become effective. Under present law, a certificate filed pursuant to section 3121(k) is effective for the period beginning with whichever of the following is designated by the organization:

(1) The first day of the calendar quarter in which the certificate is filed,

(2) The first day of the calendar quarter succeeding such quarter, or

(3) The first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, but such period may not begin earlier than the first day of the 4th calendar quarter preceding the quarter in which such certificate is filed.

This amendment removes the limitation that the period may not begin earlier than the first day of the 4th calendar quarter preceding the quarter in which such certificate is filed (see par. (3) above) and provides, in lieu thereof, that the period may not begin earlier than the first day of the 20th calendar quarter preceding the quarter in which the certificate is filed.

Section 316(a)(2) provides that the amendment made by section 316(a)(1) will apply in the case of any certificate filed under section 3121(k)(1)(A) of the code after the date of enactment of the bill.

Amendment of certificate filed before 1966

Section 316(b) of the bill amends section 3121(k)(1) of the Internal Revenue Code of 1954 by adding a new subparagraph (H). Such subparagraph (H) provides that an organization which files a certificate pursuant to section 3121(k)(1) of the code before 1966 may amend such certificate during 1965 or 1966 to make the certificate effective with the first day of any calendar quarter preceding the quarter for which such certificate originally became effective, except that such date may not be earlier than the 20th calendar quarter preceding the quarter in which such certificate is so amended. Pursuant to the new subparagraph (H), an organization which has filed, prior to 1966, a waiver certificate (without regard to whether the certificate is filed before or after the enactment of the bill) may amend such certificate so as to make it effective with the first day of any calendar quarter preceding the first quarter for which the certificate is effective without amendment. However, such a certificate may not be made effective, through an amendment, for any calendar quarter which begins earlier than the 20th calendar quarter preceding the calendar quarter in which such organization files an amendment to its certificate.

Validation of certain remuneration erroneously reported as wages by nonprofit organizations

Section 316(c)(1) of the bill amends section 105(b) of the Social Security Amendments of 1960, which provided that an employee of a nonprofit organization could, under certain circumstances, receive social security credit for remuneration erroneously reported on his behalf by the organization in any taxable period from January 1, 1951, through June 30, 1960. Section 105(b) of the Social Security Amendments of 1960, as amended by the bill, will (where the conditions prescribed by the amendment are met) permit the validation of erroneously reported wages of workers who cannot be covered

through the filing of a waiver certificate by the organization because they are no longer in the employ of the organization when it files its certificate. Under section 105(b), as amended by the bill, remuneration paid to an individual for service before the calendar quarter in which the organization files its waiver certificate under section 3121(k)(1) of the Internal Revenue Code of 1954 may be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act, to the extent that an amount has been paid as social security taxes with respect to such remuneration on or before the due date of the tax return for the calendar quarter before the calendar quarter in which the organization files its waiver certificate. This rule applies, however, only if the service would have constituted employment as defined in section 210 of the Social Security Act if the requirements of section 3121(k)(1) of the Code were satisfied, and only if the following conditions are met:

(1) the person who performed the service (or a fiduciary acting for him or his estate, or a survivor of such individual who is or may become entitled to monthly benefits under title II of the Social Security Act on his earnings record) makes a request (in such form and manner, and with such official, as the Secretary of Health, Education, and Welfare may by regulations prescribe) that such remuneration be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act;

(2) a certificate under section 3121(k)(1) of the Internal Revenue Code of 1954 is filed by the organization not later than the date on which the request for validation is made;

(3) the individual requesting the validation is no longer employed by the organization on the date the organization files its waiver certificate; and

(4) if any part of the amount paid as social security taxes as previously described with respect to such remuneration paid to an individual is credited or refunded, the amount credited or refunded, plus any interest allowed, must be repaid before January 1, 1968, or, if later, the first day of the third year after the year in which the organization files its waiver certificate.

In addition, the so-called validation of wages is to be permitted only for remuneration received for service which is performed during the period for which an organization's waiver is effective. Thus, former employees of an organization which has made erroneous reports receive no greater retroactive social security coverage than employees who are employed by the organization on the date the organization files its waiver certificate and are covered only for the retroactive period for which the certificate is made effective.

Effective dates of validating provisions

Section 316(c)(2) of the bill provides that the provisions of section 105(b) of the Social Security Amendments of 1960, as amended by the bill, will become effective upon enactment of the bill. The provisions of the existing section 105(b) of the Social Security Amendments of 1960 will continue to apply to requests for validation filed before enactment of the bill. The filing of a request by an individual for validation under the existing provisions of section 105(b) of the Social Security Amendments of 1960 does not bar him from filing another request for validation under section 105(b) as amended by the bill.

SECTION 317. COVERAGE OF TEMPORARY EMPLOYEES OF THE DISTRICT OF COLUMBIA

Sections 317(a) and 317(b) of the bill amend the Social Security Act (sec. 210(a)(7)) and the Internal Revenue Code of 1954 (sec. 3121(b)(7)) to include in the definition of employment services performed by certain temporary employees of the District of Columbia. Under the amendments, service performed in the employ of the District of Columbia, or any wholly owned instrumentality thereof, is included as employment if such service is not covered by a retirement system established by a law of the United States, except that the extension of coverage is not to apply to service performed: (1) in a hospital or penal institution by a patient or inmate thereof, (2) in a hospital of the District of Columbia by student nurses and certain other student employees (other than as a medical or dental intern or as a medical or dental resident-in-training) included under section 2 of the Act of August 4, 1947 (5 U.S.C. 1052), (3) on a temporary basis in certain emergencies, or (4) as a member of a board, committee, or council of the District of Columbia paid on a per diem, meeting, or other fee basis.

Section 317(c) of the bill amends section 3125 of the Internal Revenue Code of 1954 (relating to returns in the case of governmental employees in Guam and American Samoa) by changing the heading thereof and adding a new subsection (c). The new subsection (c) provides that the return and payment of the employee and employer taxes imposed under chapter 21 of the code (Federal Insurance Contributions Act) with respect to services performed as employees of the District of Columbia, or of any wholly owned instrumentality of the District of Columbia, may be made by the Commissioners of the District of Columbia or by such agents as they may designate. A person making such return may, for convenience of administration, make payments of the employer tax imposed under section 3111 without regard to the dollar limitations in section 3121(a)(1) (although this subsection would not authorize such person to disregard these dollar limitations as to remuneration includible in returns made by him). The purpose is to relieve a person making a return on behalf of any department or agency of the District of Columbia or any instrumentality wholly owned thereby, of any necessity for ascertaining whether any wages have been reported for a particular employee by any other reporting unit of such government or instrumentality.

Section 317(d) of the bill amends section 6205(a) of the Internal Revenue Code of 1954 by adding a new paragraph (4). The new paragraph (4) provides that the Commissioners of the District of Columbia and each agent designated by them, pursuant to section 3125 of the code, to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act, will be deemed to be a separate employer for purposes of section 6205(a) of the code, relating to adjustments of underpayments of such taxes. Thus, adjustments of underpayments will be made by the reporting unit by which the underpayment was made.

Section 317(e) of the bill amends section 6413(a) of the Internal Revenue Code of 1954 by adding a new paragraph (4). The new paragraph (4) provides that the Commissioners of the District of Columbia and each agent designated by them, pursuant to section

3125 of the code, to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act, will be deemed to be a separate employer for purposes of section 6413(a) of the code, relating to adjustments of overpayments of such taxes. Thus, adjustments of overpayments will be made by the reporting unit by which the overpayment was made.

Section 317(f) of the bill amends paragraph (2) of section 6413(c) of the Internal Revenue Code of 1954 by redesignating the heading of such paragraph (2) and by adding to such paragraph (2) a new subparagraph (F). The new subparagraph provides that for purposes of the special credit or refund provisions contained in section 6413(c)(1) of the code, the Commissioners of the District of Columbia and each agent designated by them to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act will be deemed to be a separate employer. The effect of this amendment is to permit a claim for special credit or refund, rather than a general claim for refund under section 6402(a), in any case where an employee receives more than the maximum creditable wages in a calendar year by reason of having performed services for two or more reporting units of the District of Columbia or any instrumentality wholly owned thereby.

Section 317(g) of the bill provides that the amendments made by section 317 will apply with respect to service performed after the calendar quarter in which such section is enacted and after the calendar quarter in which the Secretary of the Treasury receives a certification from the Commissioners of the District of Columbia expressing their desire to have the insurance system established by title II (and part A of title XVIII) of the Social Security Act extended to the officers and employees coming under the provisions of such amendments.

SECTION 318. COVERAGE FOR CERTAIN ADDITIONAL HOSPITAL EMPLOYEES IN CALIFORNIA

Section 318 of the bill amends section 102(k) of the Social Security Amendments of 1960 by adding a new paragraph (2) permitting the coverage agreement with the State of California to be modified to apply to certain additional services performed for any hospital affected by any modification (in the California State coverage agreement) executed pursuant to section 102(k). The services which could thus be covered are those performed by individuals who were or are employed by such State (or any political subdivision thereof) after December 31, 1959, in any position described in section 102(k). The State will have until the end of the 6th month after the month of enactment in which to so modify its agreement. Such modification will be effective with respect to services performed on or after January 1, 1962; it will also be effective with respect to services performed before January 1, 1962, where contributions in the proper amount have been paid before the date of enactment of the bill.

SECTION 319. TAX EXEMPTION FOR RELIGIOUS GROUPS OPPOSED TO INSURANCE

Amendment to the Internal Revenue Code of 1954

Section 319(a) of the bill amends section 1402(c) of the code by adding a new paragraph (6) which excepts from the term "trade or

business" the performance of service by individuals who are members of certain religious faiths during the period for which an exemption under the new subsection (h) (as added by sec. 319(c)) of section 1402 is effective with respect to them. The effect of the amendment is to exempt from the self-employment tax an individual who is granted an exemption under section 1402(h) of the code.

Amendment to title II of the Social Security Act

Section 319(b) of the bill amends section 211(c) of the Social Security Act by adding a new paragraph (6) which excepts from the term "trade or business" the performance of service by individuals who are members of certain religious faiths during the period for which an exemption under new subsection (h) (as added by sec. 319(c)) of section 1402 of the Internal Revenue Code of 1954 is effective with respect to them. The effect of the amendment is to remove from social security coverage a self-employed individual who is granted an exemption from tax under section 1402(h) of the code.

Application for exemption from self-employment tax; amendment to the Internal Revenue Code

Section 319 (c) of the bill amends section 1402 of the code by adding a new subsection (h).

Paragraph (1) of section 1402 (h) provides that any individual may file an application (in such form and manner and with such official as may be prescribed by regulations under sec. 1402 (h)) for an exemption from the tax imposed on self-employment income if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to the acceptance of the benefits of any private or public insurance making payments in the event of death, disability, old-age, or retirement or making payments toward the cost of, or providing services for, medical care. An individual who applies for exemption must, therefore, among other things, be opposed to all types of benefits or payments under titles II and XVIII of the Social Security Act.

In order that an individual may be granted an exemption from the tax imposed on self-employment income, subparagraph (A) of section 1402(h)(1) provides that the individual's application for exemption must contain, or be accompanied by, such evidence of such individual's membership in, and adherence to the tenets or teachings of, the religious sect or division thereof as the Secretary of the Treasury or his delegate may require for purposes of determining such individual's compliance with the requirements of the first sentence of paragraph (1) of section 1402(h), and subparagraph (B) of such section provides that such application must be accompanied by the individual's waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person.

In addition to the requirements of subparagraphs (A) and (B) relating to the individual who files application for exemption from the tax on self-employment income, subparagraphs (C), (D), and (E) of section 1402(h)(1) provide that an exemption may be granted

only if the Secretary of Health, Education, and Welfare makes the following findings with respect to the religious sect or division thereof of which such individual is a member:

1. That the sect or division thereof has the established tenets or teachings by reason of which the individual applicant is conscientiously opposed to the benefits of certain types of insurance;

2. That it is the practice, and has been for a period of time which the Secretary deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which, in the judgment of the Secretary, is reasonable in view of the general level of living of the members of the sect or division thereof;

3. That the sect or division thereof has been in existence continuously since December 31, 1950.

Section 1402(h)(1) of the code further provides that an exemption from the tax on self-employment income may not be granted to an individual if any benefit or other payment referred to in subparagraph (B) of such section became payable at or before the time of the filing of such waiver. This provision applies if any such benefit or other payment would have become payable at such time but for a reduction of or deduction from such benefit or payment in accordance with the provisions of section 203 (relating to reduction of insurance benefits) or 222(b) (relating to deduction on account of refusal to accept rehabilitation services) of the Social Security Act.

Paragraph (2) of section 1402(h) of the code provides rules relating to the time for filing the application for exemption described in section 1402(h)(1). Subparagraph (A) of section 1402(h)(2) provides that an individual who has self-employment income (determined without regard to the exception contained in sec. 1402(c)(6)) for any taxable year beginning after December 31, 1950 (see sec. 319(e) of the bill, relating to effective date), and ending before December 31, 1965, must file his application for exemption on or before April 15, 1966. Subparagraph (B) of section 1402(h)(2) provides that in any other case an individual must file his application for exemption on or before the due date of the return (including any extension thereof) for the first taxable year ending on or after December 31, 1965, in which he has self-employment income (determined without regard to sec. 1402(c)(6)). If an individual fails to file an application for exemption from the self-employment tax within the time prescribed by section 1402(h)(2) (A) or (B), whichever is applicable in his case, he will not be entitled to the exemption.

Paragraph (3) of section 1402(h) provides that an exemption granted to an individual pursuant to section 1402(h) will apply with respect to all taxable years beginning after December 31, 1950. However, subparagraph (A) of section 1402(h)(3) provides that such exemption will not apply for any taxable year which begins before the taxable year in which the individual who files an application for exemption first became a member of a recognized religious sect or division thereof and was an adherent of established tenets or teachings of such sect or division by reason of which he was conscientiously opposed to the acceptance of the benefits of certain types of insurance. Subparagraph (A) further provides that such exemption will not apply for any taxable year which begins before the date as of which the Secretary of Health, Education, and Welfare finds that the sect or division

thereof of which such individual is a member had the established tenets or teachings referred to in section 1402(h)(1), and that it was the practice of such sect or division to make reasonable provision for its dependent members. Subparagraph (B) of section 1402(h)(3) provides that an exemption granted pursuant to section 1402(h) will cease to be effective for any taxable year ending after the time the individual who files an application for exemption ceases to meet the requirements of the first sentence of section 1402(h)(1), or after the time as of which the Secretary of Health, Education, and Welfare finds that the sect or division thereof of which such individual is a member ceases to have the required tenets or teachings or ceases to make reasonable provision for its dependent members.

Paragraph (4) of section 1402(h) provides that in any case where an individual who has self-employment income dies before the expiration of the time prescribed in section 1402(h)(2) for filing an application for exemption pursuant to section 1402(h), such an application may be filed with respect to such deceased individual within the time prescribed in section 1402(h)(2) with respect to him by a fiduciary acting for such individual's estate or by such individual's survivor (within the meaning of sec. 205(c)(1)(C) of the Social Security Act).

Waiver of benefits; amendment to title II of the Social Security Act

Section 319(d) of the bill adds a new subsection (v) to section 202 of the Social Security Act. If an individual is granted a tax exemption under section 1402(h) of the Internal Revenue Code of 1954, no benefits or other payments are to be payable to him under title II of the Social Security Act, no payments are to be made on his behalf under part A of title XVIII (hospital insurance benefits for the aged), and no benefits or other payments are to be payable to him on the basis of the wages and self-employment income of any other person, after the filing of his waiver of benefits pursuant to section 1402(h) of the code. If the tax exemption ceases to be applicable, the waiver is to cease to be applicable to the extent benefits or other payments are based (1) on his self-employment income for and after the first taxable year for which the waiver ceases to be effective, and (2) on his wages for and after the calendar year which begins with or in such taxable year.

Effective date

Section 319(e) of the bill provides that the amendments made by section 319 will apply with respect to taxable years beginning after December 31, 1950. Section 319(e) of the bill also provides, for purposes of such effective date, that chapter 2 of the Internal Revenue Code of 1954 (secs. 1401 through 1403) shall be treated as applying to all taxable years beginning after December 31, 1950. Thus, an application for exemption from tax under section 1402(h) of the Internal Revenue Code of 1954 will be treated as an application for exemption from the tax on self-employment income imposed by the Internal Revenue Code of 1939.

Refund or credit of taxes

Section 319(f) of the bill provides that if refund or credit of any overpayment resulting from the enactment of such section 319 is prevented, by the operation of any law or rule of law, on the date of enactment of the bill or at any time on or before April 15, 1966, refund

or credit of such overpayment may, nevertheless, be made or allowed if claim therefor is filed on or before April 15, 1966. Section 319(f) further provides that no interest is to be allowed or paid on any overpayment resulting from the enactment of section 319.

SECTION 320. INCREASE IN EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

Section 320 of the bill raises the maximum amount of annual earnings subject to social security tax and counted toward benefits (the contribution and benefit base) from $4,800 to $5,600 for the years 1966 through 1970, and from $5,600 to $6,600 beginning with 1971.

Amendments to Title II of the Social Security Act

Definition of wages

Section 320(a)(1) of the bill amends section 209(a) of the Social Security Act (defining wages) to make the $5,600 contribution and benefit base applicable to wages paid after 1965 and before 1971 and to make the $6,600 base applicable to wages paid after 1970.

Definition of self-employment income

Section 320(a)(2) amends section 211(b)(1) of the act (defining self-employment income) to make the $5,600 contribution and benefit base applicable for taxable years ending after 1965 and before 1971 and to make the $6,600 base applicable for taxable years ending after 1970.

Quarter of coverage

Section 320(a)(3) amends clauses (ii) and (iii) of section 213(a)(2) of the act (defining quarter of coverage) to provide that an individual will be credited with a quarter of coverage for each quarter of a calendar year after 1965 and before 1971 if his wages for such year equal $5,600 (rather than $4,800 as in present law) and with a quarter of coverage for each quarter of a calendar year after 1970 if his wages for such year equal $6,600. An individual will also be credited with a quarter of coverage for each quarter of a taxable year ending after 1965 and before 1971 in which the sum of his wages and self-employment income equals $5,600 (rather than $4,800) and for each quarter of a taxable year ending after 1970 in which the sum of his wages and self-employment income equals $6,600.

Average monthly wage

Section 320(a)(4) amends section 215(e)(1) of the act (relating to the amount of annual earnings that can be counted in computing an individual's average monthly wage) so as to increase from $4,800 to $5,600, effective for calendar years after 1965 and before 1971, and from $5,600 to $6,600, effective for calendar years after 1970, the maximum amount of annual earnings that may be counted in the computation of an individual's average monthly wage for purposes of determining benefit amounts.

Amendments to the Internal Revenue Code of 1954

Definition of self-employment income

Section 320(b)(1) of the bill amends section 1402(b)(1) of the Internal Revenue Code of 1954 (defining self-employment income) by increasing the maximum annual limitation on self-employment income subject to the self-employment tax from $4,800 to $5,600 for taxable years ending after 1965 and before 1971, and from $5,600 to $6,600 for taxable years ending after 1970.

Definition of wages

Section 320(b)(2) amends section 3121(a)(1) of the code (defining wages) by increasing the maximum annual limitation on wages subject to social security tax from $4,800 to $5,600 for calendar years after 1965 and before 1971, and from $5,600 to $6,600 for calendar years after 1970.

Federal service

Section 320(b)(3) amends section 3122 of the code (relating to Federal service) so as to conform its provisions to the changes made in increasing the contribution and benefit base from $4,800 to $5,600 for calendar years after 1965 and before 1971, and to $6,600 for calendar years after 1970.

Returns in the case of governmental employees in Guam and American Samoa

Section 320(b)(4) amends section 3125 of the code (relating to governmental employees in Guam and American Samoa) so as to conform its provisions to the $5,600 contribution and benefit base for calendar years after 1965 and before 1971, and to the $6,600 base for calendar years after 1970. (These increases in the base will also apply to the temporary employees of the District of Columbia who are included in section 3125 by section 317(c) of the bill.)

Special refunds of employee tax

Sections 320(b)(5) and 320(b)(6) amend section 6413(c) of the code (relating to special refunds of social security tax paid by an employee on aggregate wages in excess of $4,800 received by him from more than one employer during a calendar year) so as to conform the special refund provisions to the $5,600 contribution and benefit base for calendar years after 1965 and before 1971, and to the $6,600 base for calendar years after 1970.

Effective Date

Section 320(c) provides effective dates for the changes made by the section. The amendments made by section 320 (a)(1) and (a)(3)(A) and by section 320(b) (except par. (1)) are applicable only with respect to remuneration paid after December 1965; the amendments made by section 320 (a)(2), (a)(3)(B), and (b)(1) are applicable only with respect to taxable years ending after 1965; and the amendments made by section 320(a)(4) are applicable only with respect to calendar years after 1965.

SECTION 321. CHANGES IN TAX SCHEDULES

Section 321 of the bill provides new schedules of social security tax rates, with the rates provided for hospital insurance being set forth in schedules which are separate from those provided for old-age, survivors, and disability insurance.

Self-employment tax

Section 321(a) of the bill amends section 1401 of the Internal Revenue Code of 1954 to provide new schedules of social security tax rates on self-employment income.

Subsection (a) of the amended section 1401 provides a schedule of tax rates on self-employment income for old-age, survivors, and disability insurance. Under present law the rates of self-employment tax for old-age, survivors, and disability insurance are as follows:

Taxable years beginning after—	*Tax rate (percent)*
1962 (and before 1966)	5.4
1965 (and before 1968)	6.2
1967	6.9

Under the bill, the rates of self-employment tax for old-age, survivors, and disability insurance will be as follows:

Taxable years beginning after—	*Tax rate (percent)*
1965 (and before 1969)	6.0
1968 (and before 1973)	6.6
1972	7.0

Subsection (b) of the amended section 1401 provides a schedule of tax rates on self-employment income for hospital insurance. The rates of self-employment tax provided for hospital insurance are as follows:

Taxable years beginning after—	*Tax rate (percent)*
1965 (and before 1967)	0.35
1966 (and before 1973)	.50
1972 (and before 1976)	.55
1975 (and before 1980)	.60
1979 (and before 1987)	.70
1986	.80

The new section 1401(b) provides that, for purposes of the tax imposed in respect of hospital insurance, the exclusion of employee representatives by section 1402(c)(3) of the code will not apply. Thus, the performance of service by an individual as an employee representative, as defined in section 3231(c) of the code (the Railroad Retirement Tax Act), is included in the term "trade or business" as defined in section 1402(c) for purposes of the tax imposed by the new section 1401(b).

Taxes on employees and employers

Section 321(b) and 321(c) of the bill amend section 3101 and section 3111, respectively, of the Internal Revenue Code of 1954 to provide new schedules of social security tax rates on wages for both employees and employers.

Subsection (a) of the amended section 3101 and subsection (a) of the amended section 3111 provide schedules of tax rates on wages

for old-age, survivors, and disability insurance. Under present law the tax rates for employees and employers are as follows:

Calendar years—	*Tax rate employer and employee, each (percent)*
1963–65, inclusive	3⅝
1966–67, inclusive	4⅛
1968 and after	4⅝

Under the bill, the rates for employees and employers for old-age, survivors, and disability insurance will be as follows:

Calendar years—	*Tax rate employer and employee, each (percent)*
1966–68, inclusive	4.0
1969–72, inclusive	4.4
1973 and after	4.8

Subsection (b) of the amended section 3101 and subsection (b) of the amended section 3111 provide schedules of tax rates on wages for hospital insurance. The employee and employer tax rates for hospital insurance are as follows:

Calendar years—	*Tax rate employer and employee, each (percent)*
1966	0.35
1967–72, inclusive	.50
1973–75, inclusive	.55
1976–79, inclusive	.60
1980–86, inclusive	.70
1987 and after	.80

For purposes of the employee tax and the employer tax imposed by the new sections 3101(b) and 3111(b), respectively, the exception from employment contained in paragraph (9) of section 3121(b) of the code is made inapplicable. Thus service performed by an employee as defined in section 3231(b) of the code (the Railroad Retirement Tax Act) constitutes employment, unless excluded under some paragraph (other than paragraph (9)) of section 3121(b), for purposes of determining wages subject to the employee and employer taxes imposed by the new sections 3101(b) and 3111(b).

Effective dates

Section 321(d) of the bill provides that the amendments made by section 321(a) will apply only with respect to taxable years which begin after December 31, 1965, and that the amendments made by sections 321(b) and 321(c) will apply with respect to remuneration paid after December 31, 1965.

SECTION 322. REIMBURSEMENT OF TRUST FUNDS FOR COST OF NONCONTRIBUTORY MILITARY SERVICE CREDITS

Section 322 of the bill amends section 217(g) of the Social Security Act to revise the provisions for the reimbursement of the trust funds for the cost of benefits based on military service in the period from September 16, 1940, through December 1956.

Paragraph (1) of the revised section 217(g) provides that in September 1965 and in every fifth September thereafter up to and in-

cluding September 2010, the Secretary of Health, Education, and Welfare will determine the amount which, if paid in equal annual installments, would be needed to place the old-age and survivors insurance, disability insurance, and hospital insurance trust funds in the same position at the end of June 2015 as they would be if benefits based on military service in the period from September 16, 1940, through December 1956 had not been provided.

Paragraph (2) of the revised section 217(g) authorizes annual appropriations to each of the trust funds in the amounts determined under paragraph (1) for each fiscal year in the 50 fiscal years, 1966–2015, as reimbursement for the costs of paying benefits based on military service in the period from September 16, 1940, through December 1956.

Paragraph (3) of the revised section 217(g) authorizes a final appropriation to each of the trust funds for the fiscal year ending June 30, 2016, to place the trust funds in the same position in which they would have been on June 30, 2015, if benefits based on military service in the period from September 16, 1940, through December 1956 had not been provided.

Paragraph (4) of the revised section 217(g) provides for annual appropriations to the old-age and survivors insurance, disability insurance, and hospital insurance trust funds to meet the costs of paying benefits after June 30, 2015, based on military service in the period from September 16, 1940, through December 1956.

SECTION 323. ADOPTION OF CHILD BY RETIRED WORKER

Section 323(a) of the bill amends section 202(d) of the Social Security Act (relating to child's insurance benefits) by striking out the last sentence in paragraph (1) (relating to adoptions by disabled workers) and by adding two new paragraphs (9) and (10). The new paragraph (9) of section 202(d) in effect retains the existing provisions relating to adoptions by disabled workers and makes such provisions applicable in the case where the worker is entitled to old-age insurance benefits and was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits. The effect of the new paragraph (10) of section 202(d) is to restrict the payment of child's insurance benefits when a child is adopted by a worker after the worker became entitled to old-age insurance benefits (without first becoming entitled to disability insurance benefits) by adding the following new requirements: (1) the child must have been living with the worker at the time the worker became entitled to old-age insurance benefits or adoption proceedings had begun at or before that time; (2) the child must have been receiving at least one-half of his support from the worker for the entire year before the worker became entitled to old-age insurance benefits or before a period of disability began which continued until he became entitled to old-age insurance benefits; and (3) the adoption must have been completed within 2 years after the worker became entitled to old-age insurance benefits.

Section 323(b) of the bill provides that the new requirements (added by sec. 323(a)) will be effective with respect to applications for child's insurance benefits on or after the date of enactment of the bill. The requirement that adoption be completed within 2 years after the

worker became entitled to benefits is not to apply in any case where a child is adopted within 1 year after the month in which the bill is enacted.

SECTION 324. EXTENSION OF PERIOD FOR FILING PROOF OF SUPPORT AND APPLICATIONS FOR LUMP-SUM DEATH PAYMENT

Section 324(a) of the bill amends section 202(p) of the Social Security Act. The amended section 202(p) provides that in any case where the proof of support required in connection with an application for husband's insurance benefits, widower's insurance benefits, or parent's insurance benefits, or the application for a lump-sum death payment, is not filed within the 2-year period prescribed in the applicable sections of the law and where there was good cause for failure to file such proof or application, the application or proof may be filed at any time after the expiration of the 2-year period and will be deemed to have been filed within that period. Under existing law an extension of only 2 additional years is provided in such cases.

Section 324(b) of the bill provides that the amendment made by subsection (a) will be effective with respect to monthly benefits and lump-sum death payments based on applications filed in or after the month of enactment of the bill.

SECTION 325. TREATMENT OF CERTAIN ROYALTIES FOR RETIREMENT TEST PURPOSES

Section 325(a) of the bill amends section 203(f)(5) of the Social Security Act, relating to the determination of a person's net earnings and net loss from self-employment for retirement test purposes, by adding a new subparagraph (D). The new subparagraph provides that, in determining the net earnings from self-employment of a beneficiary who has attained age 65, there is to be excluded in computing his gross income from a trade or business any royalties received in or after the year in which he attained age 65 if he shows to the satisfaction of the Secretary of Health, Education, and Welfare that the royalties are attributable to a copyright or patent which was obtained before the taxable year in which he attained age 65 and that the property to which the copyright or patent relates was created by his own personal efforts.

Section 324(b) of the bill provides that the changes made by subsection (a) will be effective for taxable years beginning after 1964.

SECTION 326. AMENDMENTS PRESERVING RELATIONSHIP BETWEEN RAILROAD RETIREMENT AND OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEMS

Section 326(a) of the bill makes a technical amendment to section 1(q) of the Railroad Retirement Act of 1937 to preserve the existing relationship between such act and title II of the Social Security Act. Under this amendment, references to the Social Security Act in the Railroad Retirement Act of 1937 will be considered to be references to the Social Security Act as amended in 1965.

Section 326(b) of the bill amends section 5(l)(9) of the Railroad Retirement Act of 1937, relating to situations where social security credits are transferred to the railroad retirement program. Benefits to survivors of a railroad employee are payable either under the railroad retirement program or the social security program, but not both, on the basis of the employee's combined earnings under both programs. In general, benefits are payable under the railroad retirement program if the individual has a current connection with the railroad industry at the time of his death. The compensation for railroad service is creditable up to $5,400 a year for this purpose. However, under present law, where an individual has less than the maximum of $5,400 in creditable compensation for a year, only enough of his wages from employment subject to title II of the Social Security Act can be added to his compensation to increase the combined creditable earnings to $4,800, the present limit on wages for a year under title II of the Social Security Act. To take into account the increases made by section 320 of the bill in the maximum amount of annual earnings creditable under social security, section 326(b) of the bill amends section 5(l)(9) of the Railroad Retirement Act of 1937 to permit the crediting of wages for a year in such an amount as to cause the combined total earnings to be as much as the new earnings and tax base under social security—$5,600 a year for the years 1966 through 1970, and $6,600 a year for years after 1970.

SECTION 327. TECHNICAL AMENDMENT RELATING TO MEETINGS OF BOARD OF TRUSTEES OF THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE TRUST FUNDS

Section 327 of the bill amends section 201(c) of the Social Security Act to require the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund to meet at least once each calendar year, rather than once each 6 months as required under present law. (A similar provision for annual meetings of the Board of Trustees is included in the provisions of the bill (discussed above) creating the Federal Hospital Insurance Trust Fund and the Federal Supplementary Health Insurance Benefits Trust Fund.)

TITLE IV—PUBLIC ASSISTANCE AMENDMENTS

SECTION 401. INCREASED FEDERAL PAYMENTS UNDER PUBLIC ASSISTANCE TITLES OF THE SOCIAL SECURITY ACT

Section 401(a) of the bill amends section 3(a)(1) of the Social Security Act. The first step of the formula by which Federal payments to States with approved plans for old-age assistance under title I are determined is changed so as to provide Federal sharing in 31/37ths of the first $37 of the average monthly assistance payment instead of 29/35ths of the first $35 of the average monthly assistance payment. The amendment also has the effect of applying the Federal percentage in the second step of the present formula to an additional $38, instead

of the present additional $35, of the State's average payment. The additional Federal share in State expenditures for medical care, determined on the basis of the Federal medical percentage of the next $15 of a State's average payment, available under the third step of the present formula, is continued, thus giving under the formula as changed by the bill a potential Federal participation in State expenditures up to an average of $90. In addition, the formula is restated for the second and third steps, so as to give recognition to the State's expenditures for medical care before applying the Federal percentage to the remaining expenditures for which Federal participation is available. The formula, as restated by section 401 (a) of the bill, would pay States, in addition to the amount computed under section 3(a) (1) (A) of the Social Security Act, and in lieu of the amounts now computed under section 3(a)(1) (B) and (C) of such act, the larger of the following:

(i) (I) the Federal percentage (as defined in sec. 1101(a)(8)) of all expenditures for old-age assistance in excess of expenditures counted under clause (A), but not counting so much of the excess as exceeds $38 times the total number of recipients of old-age assistance; plus

(II) 15 percent of the State's expenditures in the form of medical care, up to a maximum of $15 times the total number of recipients of old-age assistance; or

(ii) (I) the Federal medical percentage (as defined in sec. 6(c)) of all expenditures in excess of expenditures counted under clause (A), but not counting expenditures that exceed (a) $52 times the total number of recipients, or (b) if smaller, the total expenditures for medical care plus $37 times the total number of recipients; plus

(II) the Federal percentage of all expenditures in excess of expenditures counted under clause (A) and the provisions of clause (B)(ii) described in these paragraphs (ii) (I) and (II), but not counting so much of the excess as exceeds $38 times the total number of recipients.

Section 401(b) of the bill makes corresponding changes in title XVI of the Social Security Act.

Section 401(c) of the bill amends section 403(a)(1) of the Social Security Act so as to change the formula by which the Federal share of aid to families with dependent children is determined. The present share of 14/17ths of the first $17 of the average monthly assistance payment is increased to 5/6ths of the first $18 of such payment. The ceiling for Federal participation is raised from $30 a month to $32 a month per recipient.

Sections 401(d) and 401(e) of the bill amend sections 1003(a)(1) and 1403(a)(1), respectively, of the Social Security Act so as to change the formula by which the Federal share of aid to the blind or aid to the permanently and totally disabled is determined. The present share of 29/35ths of the first $35 of the average monthly assistance payment is increased to 31/37ths of the first $37 of such payment, and the ceiling for Federal participation is raised from $70 a month to $75 a month per recipient.

Section 401(f) of the bill provides that the amendments made by the preceding provisions of section 401 will apply to expenditures

made after December 31, 1965, under a State plan approved under title I, IV, X, XIV, or XVI of the act.

SECTION 402. PROTECTIVE PAYMENTS

Sections 402(a) and 402(b) of the bill amend sections 6(a) and 1605(a), respectively, of the Social Security Act (as such sections are amended by section 221 of the bill), to extend the definitions of "old-age assistance" and "aid to the aged, blind, or disabled" to include protective payments—i.e., payments made on behalf of the recipient to an individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of the recipient. The State plan under which the payments are made must include provision for—

(1) determination by the State agency that protective payments are necessary because, by reason of a physical or mental condition, the recipient is so unable to manage funds that payments to him would be contrary to his welfare;

(2) making payments in this form only when they (together with other income and resources) will meet all the needs of the individuals with respect to whom they are made, under rules otherwise applicable under the State plan for determining need and the amount of aid or assistance paid;

(3) special efforts to protect the welfare of the recipient and to improve, to the extent possible, his capacity for self-care and ability to manage funds;

(4) periodic review by the State agency to determine whether payments in this form are still necessary, with provision for termination of such payments if not necessary and for seeking judicial appointment of a guardian or legal representative when such action will best serve the interests of the recipient; and

(5) opportunity for a fair hearing before the State agency on the determination that protective payments are necessary.

Section 402(c) of the bill provides that the amendments made by the preceding provisions of section 402 will apply to expenditures made after December 31, 1965, under a State plan approved under title I or XVI of the act.

SECTION 403. DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED UNDER ASSISTANCE PROGRAMS FOR THE AGED

Section 403 of the bill amends sections 2(a)(10)(A) and 1602(a)(14) of the Social Security Act, effective January 1, 1966. These sections of the Social Security Act allow the States in determining need for old-age assistance or for aid to the aged, blind, or disabled (insofar as it relates to the aged) to disregard, of the first $50 per month of earned income, not more than the first $10 thereof plus one-half of the remainder. Under the amendments made by the bill, these amounts would be increased to $80 and $20, respectively; thus, in determining need for such assistance or aid, the State agency may disregard, of the first $80 of earned income for any month, not more than the first $20 thereof plus one-half of the remainder.

SECTION 404. ADMINISTRATIVE AND JUDICIAL REVIEW OF PUBLIC ASSISTANCE DETERMINATIONS

Section 404 of the bill amends title XI of the Social Security Act by adding a new section 1116 designed to provide for administrative and judicial review of certain administrative determinations made after December 31, 1965, with respect to State plans under the public assistance titles of such act (including the new title XIX added by sec. 121 of the bill).

Under the new section 1116(a)(1), the Secretary of Health, Education, and Welfare must, not later than 90 days after a State submits a plan to him for approval under one of the public assistance titles, make a determination as to whether it fulfills the conditions for approval specified in such title. Such 90-day period may be extended by written agreement of the Secretary and such State.

Section 1116(a)(2) provides that a State which is dissatisfied with such a determination may, within 60 days of notification thereof, petition the Secretary to reconsider his determination of disapproval. The Secretary must thereupon schedule a hearing and notify the State of the time and place. The hearing must be held not less than 20 days nor more than 60 days after the date the State is given notice thereof, unless the Secretary and the State agree in writing to another time. The decision of the Secretary to affirm, modify, or reverse his original determination must be made within 60 days after the hearing is concluded.

Section 1116(a)(3) provides that a State which is dissatisfied with a final determination by the Secretary on such a reconsideration or with his final determination (to withhold funds) under section 4, 404, 1004, 1404, or 1604 of the Social Security Act, or under section 1904 of such act (as added by section 121(a) of the bill), may, within 60 days of notification thereof, petition the United States court of appeals for the circuit in which the State is located to review such determination. The clerk of such court will forthwith transmit a copy of the petition to the Secretary, who will thereupon file in the court the record of the administrative proceedings as provided in 28 U.S.C. 2112.

Section 1116(a)(4) makes the Secretary's findings of fact conclusive unless they are substantially contrary to the weight of the evidence. The court is authorized, for good cause shown, to remand the case to the Secretary to take further evidence. In such case, the Secretary may make new or modified findings of fact and may modify his previous action, and he will certify to the court the record of such additional proceedings. Such findings of fact will likewise be conclusive unless substantially contrary to the weight of evidence.

Section 1116(a)(5) vests jurisdiction in the court to affirm the Secretary's action or to set it aside, in whole or in part. The judgment is reviewable by the Supreme Court upon certiorari or certification as provided in 28 U.S.C. 1254.

Section 1116(b) provides that, for purposes of obtaining the administrative and judicial reviews authorized under the new section 1116(a), any amendment of an approved State plan may, at the State's option, be treated as the submission of a new State plan.

Section 1116(c) provides that action pursuant to an initial determination of the Secretary described in section 1116(a) is not to be stayed pending reconsideration. In the event, however, that the

Secretary subsequently determines that such initial determination was incorrect, the funds incorrectly withheld or otherwise denied must be restored to the State forthwith in a lump sum.

Section 1116(d) provides that the State is entitled to and upon request must receive reconsideration of any determination by the Secretary to disallow Federal financial participation in any item or class of items for which the State claimed such participation under a public assistance title of the Social Security Act (including the new title XIX, added by the bill).

SECTION 405. MAINTENANCE OF STATE PUBLIC ASSISTANCE EXPENDITURES

Section 405 of the bill amends title XI of the Social Security Act by adding a new section 1117 designed to assure the maintenance of State effort in the financing of approved State plans under the public assistance titles of such act.

The new section 1117(a) provides that any increase in the Federal payments to a State for any quarter in the period January 1, 1966, through June 30, 1969—i.e., the increase in the total of the amounts otherwise payable for such quarter pursuant to determinations made under sections 3, 403, 1003, 1403, and 1603 of such act and under section 1903 of such act (as added by section 121(a) of the bill)—will be reduced to the extent that the State has not maintained expenditures from State and local funds of at least the same amount as was spent under its approved plans in a base period against which current quarter expenditures would be measured.

The amount of the reduction, if any, for a current quarter would be the amount by which—

(1) the excess of (A) the total of the Federal shares determined for the State under all of the sections of the act referred to above for such quarter over (B) the total of the Federal shares determined under sections 3, 403, 1003, 1403, and 1603 of the Act for the same quarter of fiscal year 1965, is greater than

(2) the excess of (A) the total expenditures for the current quarter under all of the State's approved plans (including its plan under the new title XIX) over (B) the total of the expenditures under all of its plans under titles I, IV, X, XIV, and XVI for the same quarter of fiscal year 1965.

The new section 1117(a) also gives the State the option to substitute (with respect to each of the quarters of any fiscal year) for the amount determined under paragraph (1)(B) above—

(3) the total of the Federal shares determined for the State for the same quarter in fiscal year 1964; or

(4) the average of the totals determined for each quarter in fiscal year 1964 or fiscal year 1965.

If the State elects the substitution under paragraph (3), there will be substituted for the amount determined under paragraph (2)(B) the total expenditures under its plans approved under titles I, IV, X, XIV, and XVI for the quarter referred to in paragraph (3). If the State elects the substitution under paragraph (4) for either of the years referred to therein, there will be substituted for the amount determined under paragraph (2)(B) the average of the total expenditures under such approved plans for each quarter in the same fiscal year.

Where the State has elected to substitute under paragraph (3) or (4), that election will apply with respect to all quarters in the fiscal year for which the substitution (under paragraph (3) or (4), as the case may be) has been elected.

The new section 1117(b) provides that expenditures under any or all plans of a State approved under title I, IV, X, XIV, XVI, or XIX (as added by the bill), and the reduction determined with respect thereto under such section 1117, will be determined on the basis of data in the quarterly reports of the State to the Secretary pursuant to and in accordance with his requirements under such titles; and determinations so made will be conclusive for purposes of such new section.

The new section 1117(c) provides that if a reduction is required under section 1117 (a) and (b) in the total of the Federal shares determined for a State under sections 3, 403, 1003, 1403, 1603, and 1903 (as added by the bill) for any quarter, the Secretary is to determine which of such amounts should be reduced and the extent thereof in such way as he deems will best further the purpose of maintaining State effort under the State's federally aided public assistance programs, and with the total of such reductions equalling the reduction required under section 1117 (a) and (b).

SECTION 406. DISREGARDING OASDI BENEFIT INCREASE, AND CHILD'S INSURANCE BENEFIT PAYMENTS BEYOND AGE 18, TO THE EXTENT ATTRIBUTABLE TO RETROACTIVE EFFECTIVE DATE

Section 406 of the bill permits a State, notwithstanding the requirements in titles I, IV, X, XIV, and XVI of the Social Security Act for the consideration of income and resources in determining need for aid or assistance under a plan of the State approved under any such title, to disregard the amount of any OASDI monthly insurance payment to a beneficiary which is attributable to months before the month he receives such payment, but only to the extent it is also attributable (1) to the increase in such insurance benefits resulting from the enactment of section 301 of the bill, or (2) to the payment of child's insurance benefits after attainment of age 18, in the case of children attending shcool, resulting from the enactment of section 306 of the bill.

SECTION 407. EXTENSION OF GRACE PERIOD FOR DISREGARDING CERTAIN INCOME FOR STATES WHERE LEGISLATURE HAS NOT MET IN REGULAR SESSION

Section 407 of the bill provides that, notwithstanding section 701 of the Economic Opportunity Act of 1964 (enacted August 20, 1964), funds to which a State is otherwise entitled under the public assistance titles of the Social Security Act (including title XIX as added by the bill) for any period before the first month following the month of adjournment of the State's first regular legislative session adjourning after August 20, 1964, will not be withheld because of action taken pursuant to a statute of the State which prevents the State from complying with the requirements of section 701(a) of the Economic

Opportunity Act of 1964 (relating to the disregard of certain income in determining need for federally aided public assistance).

SECTION 408. TECHNICAL AMENDMENTS TO ELIMINATE PUBLIC ASSISTANCE PROVISIONS WHICH BECOME OBSOLETE IN 1967

Section 407 of the bill makes a series of technical amendments to provisions of the Social Security Act (and to section 618 of the Revenue Act of 1951). With one exception, such amendments become effective July 1, 1967. Such amendments would eliminate various provisions in present law made obsolete by the enactment of section 121(b) of the bill. Under such section 121(b), for any period after June 30, 1967, Federal financial participation in vendor medical care payments for needy individuals will no longer be available to any State under titles I, IV, X, XIV, or XVI of the Social Security Act, and can only be provided with respect to State plans approved under the new title XIX of such act (as added by sec. 121(a) of the bill); similarly, for any period after June 30, 1967, Federal financial participation in medical assistance for the aged will no longer be available under title I or XVI and can only be provided with respect to State plans approved under the new title XIX.

Section 408(i)(1) of the bill changes the limitation in section 1108 of the Social Security Act on payments to Puerto Rico, the Virgin Islands, and Guam. Under section 408(i)(2) of the bill, these changes are effective for fiscal years beginning on or after the date on which the plan of any such jurisdiction under title XIX of such Act (as added by the bill) is approved, or beginning on or after July 1, 1967, whichever is earlier.

V. SEPARATE VIEWS OF THE REPUBLICANS ON H.R. 6675

General Statement

The Republican members of the committee are unanimous in their opposition to the provisions of this bill providing for hospitalization for the aged financed through the social security tax system. For the most part, we support and favor the other amendments to the social security laws as contained in the bill, many of which were proposed by Republicans.

We also fully support the concept that adequate health insurance should be made available to the aged at a reasonable cost. Such a program, however, should be voluntary. It should reflect ability to pay. Participation on the part of the Government should be financed out of the general revenues, and not by a regressive payroll tax upon a segment of the population, many of whom may be least able to pay for health insurance for others.

We offer a substitute program of health insurance (H.R. 4351) more comprehensive in benefits than the combined program proposed in parts 1 and 2 of title I of the committee bill. Our proposal has broad Republican sponsorship (H.R. 4351, H.R. 4352, H.R. 4353, H.R. 4354, H.R. 4355, H.R. 4356, H.R. 4357, H.R. 4358, H.R. 4519, H.R. 5022, H.R. 5031, H.R. 5582, H.R. 6690). It is predicated upon the voluntary enrollment concept, a principle which the majority recognizes in the medical services program which was added to the administration's original "medicare" bill during the closing days of the committee's deliberations. If the enrollment principle is sound for the supplemental program in the committee bill, it should be applied across the board under a uniform comprehensive health insurance program such as that offered in the Republican bills. Not only are the benefits more extensive, but it also provides protection for catastrophic illness. The Republican program is described elsewhere in this report.

Republican Opposition to Hospitalization Benefits Under Social Security

PRELIMINARY STATEMENT

In opposing hospitalization for the aged under social security, the Republican members of the committee are not unmindful of the increased cost of private health insurance for those over age 65. We believe that the reliance on a payroll tax to finance a hospitalization program jeopardizes the cash benefit program under the social security system by imposing upon that system a liability to finance undetermined future service benefits. The magnitude of that liability should cause concern to anyone dedicated to the preservation of social security cash benefits.

The committee bill would impose upon today's workers a liability of approximately $35 billion for hospitalization benefits solely for those already over age 65.[1] This blanket extension of benefits to those

[1] An additional $3.3 billion will be financed out of general revenues, making a total of $38.3 billion as the cost of the hospital benefit program for those already now age 65.

over age 65 could only be justified on the basis that all of the aged are in dire need while all of those who will be required to pay the additional payroll taxes have ample means. This is a wholly unrealistic assumption. The shifting of a $35 billion liability from those presently retired to the active work force cannot be reconciled on the basis of "ability to pay."

The hospitalization program proposed in this bill, as the majority now admits, was "oversold." In an effort to avoid the disillusionment and dissatisfaction which was bound to result from the general misunderstanding with respect to the benefits in the administration's program, the committee added a supplemental voluntary insurance program.

There is an equal, or even greater, lack of understanding with respect to the taxes which may ultimately be required to finance these obligations. The so-called medicare program has been widely advanced as providing *prepaid* medical care for the aged, *at a cost of only a few cents per week.* This is equally misleading.

Benefits financed through a payroll tax carries the erroneous implication of "entitlement." The recipients have been led to believe that these benefits become a matter of right. Both cash benefits and hospital benefits under the social security program will be continued only so long as the active worker is willing to pay the taxes required to finance those benefits. By the adminission of the former Secretary of Health, Education, and Welfare before the last Congress, the combined payroll tax in the committee bill exceeds the limits of an acceptable payroll tax.

Recognizing this, the committee bill makes an obvious effort "to soften the blow" on the work force. At the outset the hospital benefits will be financed with only a fraction of the ultimate tax that must be assessed to finance the benefits. Notwithstanding the increases in cash benefits, the regular social security tax rate provided in the bill for 1966 is less than the rate called for in existing law. The taxes which will be paid on account of today's younger worker are not commensurate with the benefits provided for him at age 65. When he understands this, will the worker be willing to pay the tax? If not, both cash benefits and hospital benefits will be in jeopardy.

COMMITTEE BILL COSTS MORE FOR LESS PROTECTION THAN REPUBLICAN PROPOSAL

The majority has finally recognized, as the Republicans long contended, that the limited hospitalization benefits provided for under the administration's original bill (H.R. 1)—widely advertised as "medicare"—were woefully inadequate. In an effort to meet this criticism, the Democrats borrowed from the Republican proposal and added a voluntary program of insurance for medical services. The committee bill now provides for a mandatory hospitalization program financed by a payroll or social security tax, together with a voluntary program for medical services financed partially by contributions and partially out of the general revenues of the Treasury. Notwithstanding diverse means of enrollment and financing, the package of benefits offered under the dual approach proposed in the committee bill still does not fully meet the needs of the aged.

While the adoption of the voluntary medical insurance program partially remedies the inadequacy of the administration's original

"medicare" bill, the committee bill still fails to cover two of the basic concerns of the aged; namely (1) the high and recurrent cost of drugs, and (2) the ever-present risk of a catastrophic illness. Both were covered in the substitute proposal offered by the Republicans.

On the other hand, the cost to the taxpayer—whether he pays a payroll tax or an income tax—of the comprehensive health insurance offered by the Republicans, is less than the cost of the administration's original hospital program. In preparing its estimates, the Department of Health, Education, and Welfare has assumed 80 percent participation in the voluntary medical insurance program in H.R. 6675. On the same assumption, the relative cost of the Republican proposal would be $400 million less than the cost of the administration's hospital benefits program alone.

Comparative cost of H.R. 6675 and Republican proposal based on 80 percent participation

[In billions]

	H.R. 6675	Republican proposal
Hospital benefit	$2.30	
Medical benefit	1.12	
Total, cost of program	3.42	$2.90
Less: Premium contributions	.56	1.00
To be financed by taxpayers	2.86	1.90

Source: Department of Health, Education, and Welfare.

While the estimates assume 80 percent participation, the Republicans would hope that the participation might be much greater. In fact, the Chief Actuary for the Department estimated that as many as 95 percent of the aged would participate in the Republican program. Even if we assume 100 percent participation, the net cost to the general revenues would be less than $2 billion for the first full year of coverage. This results from the fact that as participation increases, there are offsetting reductions in other programs and the tax revenue loss due to the medical deduction of $1.2 billion presently being claimed by the aged will be practically eliminated.

Net cost of Republican comprehensive health insurance proposal, 100 percent coverage

	Billions
Benefit cost	$3.65
Less:	
Premium contributions	1.25
Tax revenue from medical deduction	.25
Reduction of Federal cost for OAA–MAA programs	.35
Total	1.85
Cost to general revenues, net	1.80

In addition, the cost to the States for medical assistance to the aged would likewise be reduced, because the health insurance fund would cover a substantial part of such costs.

ELIGIBILITY PROVISIONS HIGHLY DISCRIMINATORY IN PRINCIPLE AND IN FACT

The hospitalization provisions of the committee bill, which are predicated upon the administration's original medicare proposal (H.R. 1), provide for 60 days of hospital care and related benefits for the aged irrespective of financial need, without any financial contribution from those already over age 65, and without regard to whether the individual may already be adequately protected against such costs. The bill automatically extends these benefits to all of those *presently* over age 65, and to those who attain that age before 1968, without regard to coverage under the social security system, *except that the bill excludes certain Federal civil service employees and their families irrespective of age.* Anyone reaching age 65 after 1967 must have the specified quarters of coverage under the social security system to be eligible for hospital benefits.

The committee bill thus excludes everyone who attains age 65 after 1967 without the required quarters of social security coverage. This means that until we reach that time when everyone qualifies for cash benefits under social security, there will always be those over age 65 who will not qualify for hospitalization benefits. Yet, this same group will qualify to purchase the voluntary insurance plan to cover the other medical services which was added in the committee bill.

The administration's original bill (H.R. 1) would also have excluded *all* Federal employees. The Republicans sought to make the benefits available to *all retired* Federal employees, just as the benefits are made available to all other persons over age 65. The majority rejected this proposal for the stated reason that with enactment of the Federal Employees' Health Benefits Act of 1959, the Federal Government offered adequate health insurance to its employees. However, the majority agreed to limit exclusion to those Federal employees who retire or have retired after the enactment of the 1959 act, *and their spouses.* Some 250,000 presently retired Federal employees and their spouses, and all future retirees, are excluded from the hospital benefit program.

We know of no justification for excluding any Federal employees. With respect to the Federal employee, the Government stands in role of employer, and should be governed accordingly. The majority takes the position that the hospital benefits in the bill should be denied to the retired Federal employee where other insurance is available. The health insurance provided for in the 1959 act costs the retired Federal employee about $20 per month for a retired couple. On the other hand, the hospitalization benefits in the committee bill are extended without cost to retired employees of the automotive industry, the agricultural industry, the chemical industry, and other groups notwithstanding that their employers have already provided them with complete hospitalization coverage without cost to them. The committee ignores the role of the Federal Government as an "employer" and discriminates against its own employees.

SEPARATION OF HOSPITALIZATION PROGRAM FROM SOCIAL SECURITY ILLUSORY

The bill purports to establish a separate hospital insurance fund, financed by a payroll tax, apart from the social security system. In

financing benefits for those presently over age 65, however, the bill distinguishes between the aged who are entitled to receive social security cash benefits and the aged who do not qualify for social security cash benefits. For the former, hospital benefits are to be financed by the payroll tax. For the latter, hospital benefits are to be financed out of the general revenues. If the program is, in fact, separate from the social security system, there is no basis for financing differently hospital benefits for the retired already receiving social security cash benefits as against those not entitled to cash benefits. With respect to the hospital benefit program—if it is a program separate and distinct from the social security system—neither group has made any contribution and neither has any prior entitlement to hospital benefits.

Similarly, those reaching age 65 after 1967—ineligible for the hospitalization program because they do not have the requisite social security coverage—are in no different position with respect to the hospital benefit program than are any of those presently over age 65. Yet benefits are denied to those reaching age 65 after 1967 unless they have the requisite social security coverage. Obviously, therefore, the so-called separation of the hospital benefits from the social security system of cash benefits under social security is purely illusory. It ignores the fact that the hospitalization and social security programs are linked together by a common method of financing (the payroll tax), a common wage base to which the tax is applied, and a common test for entitlement to benefits.

HOSPITALIZATION PROGRAM REAL THREAT TO INTEGRITY OF OASDI CASH BENEFITS

Under the committee bill, the hospital benefit program will be an integral part of the social security system. There is a common method of financing, applied to a common wage base, with a common test for entitlement to benefits. The bill has already been acclaimed by the administration as a program of medical care for the aged *under social security.* A real threat to the integrity of the social security cash benefit system is inherent in the committee bill.

The central fact which must be faced on a proposal to provide hospital benefits—a form of service benefit as contrasted to a cash benefit—is that it is impossible to accurately estimate its future cost. As the chairman of the Ways and Means Committee said in a speech as recently as last September: "These difficult-to-predict future costs, *when such a program is identified with the social security system,* could well have highly dangerous ramifications on the social security cash benefit." [Italic added.]

The American people must have confidence in the continued soundness of the social security program. In the past, the basis of this assurance has been the conservative nature of the assumptions upon which the social security system is based. One of these is the so-called level earnings assumption whereby the condition of the system is measured on the basis of the most recent year for which payroll information has been recorded. It is conservative in that it does not anticipate increase in earnings level even though such increases have been the history of the American economy over the long run. This safety factor which is built into the social security system comes into play because of a cash benefit structure which pays back

less, proportionately, to higher income people than to those whose average wages are lower. Thus, if future earnings increase, as they are very likely to do, this "savings" results because more people will have their benefit computed in the less weighted part of the benefit formula.

No similar assumptions can be made with respect to the hospitalization program. In order adequately to finance the hospitalization program it must be assumed either (1) that the tax rate will be continually increased or (2) that the wage base will be continually "updated" in order to provide additional funds to meet the increase in cost of the services. No one can reasonably assure the committee, or this Congress, that the actuarial cost estimates on which the program has been predicated will be realistic or valid a few years from now. Therefore, it would be unrealistic to assume that the tax rate in the bill—up to 1.60 percent on a wage base of $6,600—will adequately finance the benefits. In fact, our experience with the estimates submitted by the Department of Health, Education, and Welfare over the past 10 years with respect to the various hospital benefit programs conclusively establishes the opposite.

In 1957, the Department of Health, Education, and Welfare made estimates with respect to the cost of the original Forand bill then pending before the committee. Within a short period of time, the Department was forced to concede that those estimates were wholly inadequate. Based upon the facts known to us today, the estimated cost of that bill should have been at least double the amount of the original estimate. A similar bill with reduced benefits was introduced in 1960. Before the committee hearings were concluded on that bill, the Department had conceded that the costs were greatly underestimated. On the basis of what we know today, the Department underestimated the cost of that bill by at least one-third.

In 1963, when the King-Anderson bill (H.R. 1) was first introduced, it called for a tax rate increase of 0.50 percent (0.25 percent each on employer and employee) with a wage base increase to $5,000. When the committee conducted hearings on this bill in 1964, only 1 year later, the Department had already readjusted its estimates of the cost to increase both the tax rate and the base.

In January 1965, the Department estimated the cost of the hospitalization program in the administration's bill (H.R. 1) as equivalent to a tax of 0.84 percent on a taxable base of $5,600. Within the past few weeks, the Department has again revised its estimates upward. This escalation in cost estimates and tax rates has continued up until final action by the committee last week. Notwithstanding that benefits have been reduced from those originally proposed in H.R. 1, the committee bill now proposes a tax up to 1.6 percent on a wage base of $6,600.

Any member of the committee who is prepared to assure the Congress that these latest and most recent estimates of cost can be relied upon is ignoring 10 years of past experience. This is not to reflect upon the integrity of the actuaries who have participated in making the estimates. Uncertainty with respect to the cost of a program of this type is unavoidable.

The Congress would be wise if, in this context, it considered seriously a statement last year of Labor Minister Gilbert Granval who is responsible for France's social security system. He said in a report to President Charles de Gaulle:

"The financial breaking point is near. The solution cannot be found in the framework of the present system." He is quoted as saying that the chief drain on the French social security system has not been the retirement and other benefits but the health insurance system.

FINANCING OF HOSPITAL BENEFITS IS MISLEADING

In the committee bill, provision is made for a payroll tax using the same wage base as the social security system. The rate of tax and the wage base is, however, escalated in subsequent years. The ultimate tax rate of 1.60 percent provided for in the bill to finance the hospital benefits at a $6,600 wage base will be more than double the initial tax rate of 0.70 percent assessed on a $5,600 wage base for 1966. This "gimmick" merely postpones the full impact of the cost. It may make the program more "palatable" today, but it does not, in fact, diminish the burden on the active work force—employees, employers, and self-employed alike—who will be called upon to provide hospital benefits for those already over age 65. The real burden is merely shifted to the future.

The Department has estimated the cost of the program on a 25-year basis—the basis used in the committee bill—is the equivalent of a tax of 1.27 percent on a wage base of $5,600. Instead, the committee bill proposes to start out with a tax of 0.70 percent. This results in underfinancing the program on a level cost basis during the initial 10-year period. It requires subsequent increases in the tax rate and the wage base to a rate of 1.6 percent on a wage base of $6,600. In adopting this method of financing, we are misleading today's worker into believing that the cost of the hospital benefit is only a few cents per week. If no one paid more than the initial top rate the program would be "broke" in a couple of years.

Comparison of tax rates in H.R. 6675 with tax rate required to finance hospital benefit program on a level cost basis [1]

Year	Wage base	Tax rate	Tax	Level cost (on fixed wage base of $5,600)	Excess or (deficiency)
1966	$5,600	$0.70	$39.20	$70.12	($30.92)
1967	5,600	1.00	56.00	70.12	(14.12)
1968	5,600	1.00	56.00	70.12	(14.12)
1969	5,600	1.00	56.00	70.12	(14.12)
1970	5,600	1.00	56.00	70.12	(14.12)
1971	6,600	1.00	66.00	70.12	(24.12)
1972	6,600	1.00	66.00	70.12	(24.12)
1973	6,600	1.10	72.60	70.12	2.48
1974	6,600	1.10	72.60	70.12	2.48
1975	6,600	1.10	72.60	70.12	2.48
1976	6,600	1.20	79.20	70.12	9.08
1977	6,600	1.20	79.20	70.12	9.08
1978	6,600	1.20	79.20	70.12	9.08
1979	6,600	1.20	79.20	70.12	9.08
1980	6,600	1.40	84.40	70.12	14.28
1981	6,600	1.40	84.40	70.12	14.28
1982	6,600	1.40	84.40	70.12	14.28
1983	6,600	1.40	84.40	70.12	14.28
1984	6,600	1.40	84.40	70.12	14.28
1985	6,600	1.40	84.40	70.12	14.28
1986	6,600	1.40	84.40	70.12	14.28
1987	6,600	1.60	105.60	70.12	35.48
1988	6,600	1.60	105.60	70.12	35.48
1989	6,600	1.60	105.60	70.12	35.48
1990	6,600	1.60	105.60	70.12	35.48
1991	6,600	1.60	105.60	70.12	35.48

[1] Source: Basic data from Department of Health, Education, and Welfare.

The Department estimates $35 billion as the cost of the hospital program for those now over age 65 alone, who will not have paid 1 cent of the tax to finance these benefits. If we add to this the cost for those approaching age 65, who will have paid only a nominal tax, the total liability will exceed $133 billion. It is wholly irresponsible and unnecessary to place this burden on the payroll tax, with the representation which has frequently been made by the proponents of medicare that prepaid health insurance can be provided at a cost of only a few cents per week.

HOSPITAL INSURANCE TAX REGRESSIVE—NO MEASURE OF ABILITY TO PAY

A payroll tax is one of the most unfair and regressive taxes in our entire tax system. It applies to the first dollar of earnings. There are no exemptions, no deduction, no exclusions, and no tax credits. No consideration is given to the taxpayer's ability to pay. The president of a large corporation pays the same tax as his worker. The justification for this type of tax rests upon the basic premise of the social security system that the benefits, for which the tax is levied, are wage related. The financing of a hospital service benefit by a payroll tax represents a basic departure from that principle.

A worker earning a $3,600 wage, with a wife and two children to support, will pay total Federal income and payroll taxes of $250 for the year 1966. Of this amount, the payroll tax accounts for $162, with $18 of that amount applying to the hospitalization program. At the outset, this worker will be paying $18 per year towards financing hospital benefits for a retired couple without regard to their financial resources. The same retired couple with an income of $3,600 will pay no income tax, no social security tax, and no hospital insurance tax. They will have two less mouths to feed, and more spendable income, yet the worker will be forced to pay for their hospitalization.

FEDERAL TAX BURDEN OF MARRIED TAXPAYERS UNDER AGE 65 AND OVER AGE 65 [1]

Under age 65—Husband and wife with 2 children who take the standard deduction and have income of—

	Income tax	OASDI	Health Insurance	Total tax
$3,600				
1967	$88.00	$144.00	$18.00	$250.00
1976	88.00	172.80	21.60	282.40
1987	88.00	172.80	28.80	289.60
$4,600				
1967	$234.00	$184.00	$23.00	$441.00
1976	234.00	220.80	27.60	482.40
1987	234.00	220.80	36.80	491.60
$5,600				
1967	$402.00	$224.00	$28.00	$654.00
1976	402.00	316.80	39.60	758.40
1987	402.00	316.80	52.80	781.60

Over age 65—Husband and wife 65 or over (assumed to receive $1,200 retirement income, social security, pensions, interest, dividends, rent) with income of—

	Income	OASDI	Health Insurance	Total tax
$3,600				
1967	0	0	0	0
1976	0	0	0	0
1987	0	0	0	0
$4,600				
1967	$89.60	0	0	$89.60
1976	89.60	0	0	89.60
1987	89.60	0	0	89.60
$5,600				
1967	$224.00	0	0	$224.00
1976	224.00	0	0	224.00
1987	224.00	0	0	224.00

[1] Source: Internal Revenue Code.

PREPAYMENT FOR HOSPITAL BENEFITS A MYTH

Under the committee bill, a worker entering the work force at age 21 today will pay a payroll tax for 44 years—matched by the same amount paid on account of his wage by his employer—to finance a benefit for others. The actual cost of the hospitalization program per worker entering the work force at age 21, with interest at 3½ percent per annum, will amount to $8,590. That is what will be paid on account of the new generation of workers to finance hospital benefits for those already retired. The same amount invested in private health insurance would provide the worker with far more extensive benefits than are provided under the hospital program contained in the bill.

Hospital insurance cost under H.R. 6675 for workers at selected ages from Jan. 1, 1966, to retirement [1]

HOSPITAL INSURANCE TAX

Age	Employee tax	Employer tax	Combined
21	$2,003	$2,003	$4,006
25	1,792	1,792	3,584
35	1,264	1,264	2,528
45	742	742	1,484

HOSPITAL INSURANCE TAX COMPOUNDED WITH INTEREST AT 3½ PERCENT PER ANNUM

21	$4,295	$4,295	$8,590
25	3,586	3,586	7,172
35	2,067	2,067	4,134
45	1,025	1,025	2,050

[1] Source: Department of Health, Education, and Welfare.

The so-called prepayment concept of the committee bill is a myth. The funding of the hospital benefit program is so meager as to be meaningless. When the 21-year-old worker reaches age 65, there will not be $8,590 in the fund to finance his hospital benefits. The money will have been used to pay benefits for those who preceded him. *It is not contemplated that the amount "prepaid," or set aside in the hospital insurance fund to pay future costs, will exceed the cost of 1 year's benefits.*

Estimated progress of hospital insurance trust fund [1]

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Fund at end of year
1966	$1,578	$982	[2] $50	$17	$562
1967	2,601	2,192	66	20	925
1968	2,790	2,391	72	34	1,286
1969	2,879	2,607	78	45	1,525
1970	2,983	2,840	85	50	1,633
1971	3,327	3,055	92	55	1,868
1972	3,488	3,280	98	60	2,038
1973	3,929	3,516	105	68	2,414
1974	4,120	3,760	113	77	2,738
1975	4,267	4,028	121	84	2,950
1980	6,123	5,276	158	140	5,018
1985	7,038	6,823	205	236	7,681
1990	9,030	8,754	263	306	9,948

[1] Source: Department of Health, Education, and Welfare.
[2] Including administrative expenses incurred in 1965.

The 21-year-old worker, or indeed the 45-year-old worker, is not "prepaying" for his hospital benefits. He is really being taxed for the hospital benefits of those already retired and of the older workers who will retire before him. For example, the Department has estimated that a worker at age 50 who pays the full amount of the tax for the balance of his working years will have been taxed only to the extent of a fraction of the cost of his benefits.

Relative hospital benefit cost and taxes paid under H.R. 6675 by selected age groups over 50 years of age [1]

[In billions]

	Cost of providing hospital benefits to selected age group	Taxes paid by selected age group	Cost younger workers are required to pay to provide benefits to selected age group
(1) Individuals 65 or over on Jan. 1, 1966	$35		$35
(2) Individuals between 60 and 65 on Jan. 1, 1966	25	$1	24
(3) Individuals between 50 and 60 on Jan. 1, 1966	80	6	74
(4) All individuals 50 or over on Jan. 1, 1966 ((1) through (3) above)	$140	$7	$133

[1] Source: Department of Health, Education, and Welfare.

HOSPITAL COST REIMBURSEMENT FORMULA DESTROYS QUALITY OF MEDICAL CARE

The committee bill embodies a wholly new concept of payment for the hospital services which will be supplied to the aged under the hospital benefits program. The bill provides that the payment to the providers of such services (hospitals) will be limited to the "reasonable cost" of the services to be determined in accordance with regulations to be issued by the Department of Health, Education, and Welfare.

In other words, it makes no difference what the hospital might customarily charge for room and board, radiotherapy, or any other of the multitudinous services available for the treatment of the patient. It is immaterial, in fact, what Blue Cross or any health insurer might pay for the same service. The bill presupposes that it will cost less to render the services to the aged. Actuarially, the cost estimates relied upon in the bill are predicated on the assumption that the Department will be able to buy hospital services for the aged at a "discount" rate.

The bill requires that the Department shall fix a price—namely, "reasonable cost"—for each and every service rendered by the hospital or nursing home. The bill does not specifically define "reasonable cost." However, in fixing the reasonable cost of such services, it is admitted that charges for bad debts, charity patients, and certain unabsorbed overhead will not be allocated as a cost of the services financed under the hospitalization program.

The committee was advised that there are some 5,000 hospitals which will participate in the program. Add to this an undetermined number of nursing homes and other providers of services. The so-called reasonable cost in each case will vary. This means that every provider of services will be required to analyze its cost for every service which may be supplied to the aged, and to negotiate and

agree with the agency administering the program on the price to be charged to the aged for such service.

The hospitals are for the most part nonprofit institutions. There is hardly a hospital in the country which does not embark upon various money-raising programs in order to make up the deficit between the charges and the cost of running the hospital. Any cost which is shifted from the overage 65 patients in the cost formula prescribed by the Department, must necessarily be paid by someone. Many of the hospitals are already faced with inadequate revenues. If the hospitals are to continue in operation, someone will have to pay for the charity patients, the bad debt losses, and the unabsorbed overhead. If the entire burden is shifted from the overage 65 patients to the other patients, this will inevitably increase hospitalization costs for the patients under age 65.

In lieu of this formula, the Republicans suggested that the hospital program reimburse the provider of services at the customary rate charged for such services. This was rejected on the grounds that it would result in an overpayment on account of the aged. The Department claimed that the "reasonable cost" for the aged, as contemplated by the committee bill, will be less than the Blue Cross rates.

The consequences of the adoption of the "reasonable cost" formula should be apparent. If the hospitals are prevented from charging the customary rates to the patients over age 65, hospital costs for patients under age 65 will have to be increased in order to make up the difference. In order to reduce its losses, when the patients under age 65 can no longer bear such increases, the hospital will be forced to curtail the quality of its service.

The Department will undoubtedly contend that the services offered to those aged 65 cannot be reduced because the Department will see that this is not done. In other words, in the final analysis, so long as the "reasonable cost" formula remains in the bill, hospital care for those over age 65—and the operations of the hospital itself—will necessarily be subject to control by the Department. This is essential if the Department is to prevent the hospital from taking the only course open to it in reducing its losses, namely, to cut back on its services to the patients over age 65 who are the cause of such losses.

Republicans Offer Better Proposal for Comprehensive Health Insurance

Outline of Republican Comprehensive Health Insurance Program

We propose a program of comprehensive health insurance for everyone over age 65 equivalent to the medical insurance available to Government employees under the high option of the Government-wide indemnity plan. This plan has been described by the Department of Health, Education, and Welfare as providing the most comprehensive insurance available at this time. Our program would meet all of the medical needs of the aged, both in and out of the hospital. It will cover the catastrophic illness. It is both comprehensive in scope and comprehensive in effect.

Under this program, all persons aged 65 or over are eligible, on a uniform basis. Their participation would be voluntary; there would

be no means test. Enrollment would be during an initial enrollment period, followed by periodic enrollment periods.

For those under social security—or railroad retirement—enrollment would be exercised by an assignment of a premium contribution to be taken out of, or checked off, the individual's current social security benefit. Those not under social security would execute an application accompanying it with their initial premium contribution. State agencies would be granted an option to purchase the insurance for their old-age assistance and medical assistance for the aged recipients at a group rate.

Premium contributions by individuals would be based upon the cash benefits which they would either receive, or be entitled to receive upon reaching age 65. The premium would be 10 percent of the minimum social security benefit and 5 percent of the balance. Those receiving the lowest social security benefits would pay the least. The average premium contribution on the basis of the benefit levels in the committee bill would be about $6.50 per month per person. Persons not under social security would pay a premium equivalent to the maximum contribution of an individual under social security. The remainder of the cost of the insurance would be paid by the Federal Government out of general revenues.

Benefits would be paid out of a national health insurance fund. The fund would receive as deposits the contributions of individuals, contributions from the social security system and Railroad Retirement Board on behalf of individuals covered under those systems, State contributions for OAA and MAA recipients, and annual appropriations from the Federal Treasury. The Secretary of the Treasury would administer the fund. The insurance program would be administered by the Department of Health, Education, and Welfare, which would be charged with general administration, recordkeeping, and so forth, but would not process the claims or bills of hospitals, physicians, and the like. The Surgeon General would contract with private agencies—Blue Cross-Blue Shield, for example—which would process and pay the claims of those furnishing services and would then be reimbursed from the national health insurance fund.

Under what we propose, more medical care can be provided for those over age 65 at a savings both to the Government and to the taxpayer. For the first full year of coverage, the net cost to the Treasury for financing the Republican health insurance program, after taking into account the additional tax revenues and the savings in other Federal programs attributable to the program, will amount to less than $2 billion. While costs will increase—just as costs will increase under the programs in H.R. 6675—premium contributions will also increase under the Republican program. The taxpayer—or tomorrow's worker—does not bear the full brunt of the increases in hospital and other medical costs.

The Republican program also embodies an amendment to the Internal Revenue Code to provide for a special tax to recoup a part of the cost of the insurance from those participating who have incomes in excess of $5,000 for a single person and in excess of $10,000 for a married couple filing a joint return. In this manner, those over age 65, who are fully able to finance health insurance without Government aid, can participate in the program with the full knowledge that they are not passing on this cost to others.

REPUBLICAN PROPOSAL AVOIDS PROBLEMS INHERENT IN THE COMMITTEE BILL

The Republican proposal for a national health insurance fund, financed partially through voluntary contributions and partially through the general revenues, avoids the problems inherent in the committee bill. Health insurance for the aged is not divided into separate programs requiring separate financing and separate administration. The aged are treated just as we treat our Federal employees. Adequate insurance is provided at a cost which is well within the means of those who do not quality for State assistance.

The program provides comprehensive medical care. It is not misleading.

The insurance concept is completely voluntary. Since there is a cost to the insured, those who already have adequate programs paid for by their former employers or through associations and the like, may not elect the Government-sponsored program. To the extent that these do not participate, the cost to the Government is reduced.

The insurance concept is completely independent of the social security system. Social security benefits are used merely as a test of ability to pay in determining the amount of the premium. The assignment of a predetermined percentage of these benefits to the health insurance fund is the only relationship of the program to the social security system.

The premium contribution schedule embodies a relative needs test. For example, for a couple receiving the maximum social security benefit ($203.85), the cost of the insurance will be $13.00 per month. A couple receiving the minimum social security benefit ($66) will be able to buy the same health insurance at a cost of $5.50 per month. The amount of the Government subsidy thus varies with the economic status of the individual, as measured by social security benefits.

By including a contribution or premium charge, the cost is shared by the individual and the Government. This makes for a sounder program. This cost sharing will have a tendency to reduce excessive usage of the benefits.

The program preserves fully the role of the States in providing for those who are in need. Instead of blanketing in individuals receiving medical assistance under OAA and under MAA, as provided in the hospital benefit program of the committee bill, the States will determine the needs of these persons and are permitted to insure them as a group if the State elects to do so. It becomes possible to provide all recipients of medical care with the same type of basic protection, irrespective of their enonomic status. No distinction is made in our program between the person who participates on an individual basis, the social security recipient who elects to participate, the recipient of OAA and the recipient of MAA. All receive the same basic insurance policy.

In alternative, however, we also give the States the election under the Kerr-Mills Act, to offer alternate programs of private health insurance to the aged, which is the approach adopted in the Eldercare bills.

Republicans Support Amendments to Kerr-Mills Program

The bill expands State programs for medical assistance to the aged, blind, and the disabled, and provides grants for maternal and child health care and crippled children's services. These amendments will unquestionably bring about better medical care for those in need under the State-administered programs of medical assistance for the aged, the blind, the disabled, and for dependent children.

The Republicans supported similar amendments before the Ways and Means Committee in the last Congress. We reaffirm that position. However, the proponents of medicare would not support the medical assistance amendments at that time because they felt that such action might jeopardize—because of reducing the need for—the hospitalization program provided in H.R. 1.

Not only do the Republicans fully support these amendments to the Kerr-Mills program, but we would enlarge upon the committee bill in this respect. We would add the complete concept embodied in the Eldercare bills (H.R. 3728 and H.R. 3801) introduced by two Republican members of the committee. Under these bills, voluntary private health insurance plans may be used as the insurance intermediary. State governments, assisted by Federal funds, could offer health insurance coverage to fit the individual needs of the aged. The cost of such coverage would be paid completely out of Federal-State funds for those individuals with incomes below means established by each State. For those individuals exceeding the minimum but less than a maximum, the State could pay a part of the cost. Eligibility would be determined solely on the basis of a simple statement of annual income submitted to the appropriate State authorities.

While much of the Eldercare bills is embodied in the committee bill, we believe that the States should be specifically authorized to adopt such programs under the Kerr-Mills Act. We propose to enlarge upon the committee amendments to the Kerr-Mills Act in order to make more specific the right of the States to enter into private contracts of insurance for the aged.

OASDI Amendments Supported by Republicians

Substantially all of the amendments relating to the OASDI benefits were embodied in a bill (H.R. 288) introduced on January 4, 1965, by the ranking Republican member of the committee, and similar bills introduced by other Republicans (H.R. 3163, H.R. 3830, H.R. 3219, H.R. 4230, H.R. 4272, H.R. 4395, H.R. 4619, H.R. 4971, H.R. 5038, H.R. 5039, and H.R. 6404). These amendments could have been enacted into law long ago if considered separately from the so-called medicare program. In fact, some 20 million recipients (or their dependents) would already have been enjoying the benefits of these amendments if the proponents of medicare, at the direction of the administration, had not blocked enactment of the social security amendments in the last Congress.

Many of the amendments in the Republican bills (H.R. 288, 3161, 3219, and 3830) are now included in the committee bill. We fully support these amendments:

(1) A 7-percent increase in cash benefits, with a minimum increase of $4 for the primary insurance amount.[1]

[1] The Republican bills proposed a 7-percent increase in cash benefits with a minimum increase of $5 in the primary insurance amount.

(2) A minimum benefit of $35 for some 400,000 persons over age 72 who do not have the requisite work coverage to qualify for benefits under existing law.

(3) Liberalization of the earnings test for the aged who seek to supplement their social security benefits with part-time jobs.

(4) Extension of social security benefits for dependents attending school up to age 22 instead of age 18.

(5) Social security benefits for widows beginning at age 60, rather than at age 62.

(6) Liberalization of the gross income upon which farmers may elect to pay social security taxes.

(7) Recognition of the conscientious objection of certain long-established religious groups to the social security concept.

In addition to these amendments to the OASDI system, the Republican proposals also contained the amendments relating to the old-age assistance and other assistance programs administered by the States, which are presently included in H.R. 6675. Titles II, III, and IV of the committee bill are, for the most part, supported by the Republicans. We take satisfaction in the fact that many of these amendments—not included in the administration's bill (H.R. 1)—were contained in the bills introduced by the Republicans.

Republicans Applaud Tax Relief for Those Under Age 65 Carrying Health Insurance

Although we have made tremendous gains in public acceptance of health and accident insurance over the past decade, the taxpayer, instead of being given an incentive to enroll himself or his family in a medical plan, is penalized for doing so. Under existing law, the medical expense deduction is limited to the amount in excess of 3 percent of the taxpayer's adjusted gross income. The 3-percent limitation effectively excludes the cost of health insurance. This penalizes the taxpayer who insures himself and his family through accident and health insurance. Today, as a practical matter, a person having adequate health insurance does not get a tax deduction for either insurance costs or medical costs.

For many years, the Republicans have sought to amend the tax laws so as to treat premiums paid on account of health and accident insurance differently from other medical expense in order that a taxpayer carrying such insurance will be placed on more nearly an equal basis with a taxpayer who does not insure his medical expenses.

The committee bill partially remedies this inequity. The bill provides a separate deduction (up to a maximum $250 per year) for 50 percent of the cost of the taxpayer's expense for health insurance. The Republicans would prefer the allowance of the deduction in full. Nevertheless, we believe that "half a loaf is better than none," and we applaud the recognition, in the committee bill, of health insurance premiums as a separate deduction, not subject to the 3-percent exclusion.

John W. Byrnes.
Thomas B. Curtis.
James B. Utt.
Jackson E. Betts.
Herman T. Schneebeli.
Harold R. Collier.
Joel T. Broyhill.
James F. Battin.

ADDITIONAL SEPARATE VIEWS OF THE HONORABLE JOEL T. BROYHILL

The undersigned has joined with my Republican colleagues in the foregoing Separate Views opposing enactment of the so-called medicare program provisions of H.R. 6675, in the compulsory form in which the program was approved by the majority members of the Committee on Ways and Means.

I support the efforts to be made by the Republican minority during the House floor consideration of H.R. 6675 to delete the mandatory medicare provisions of the bill and substitute therefor a voluntary program of broader health care insurance. I file these additional separate views because I was one of the original 35 sponsors of the eldercare proposal as embodied in my bill, H.R. 3801, and I believe it appropriate to discuss the superiority of the eldercare proposal over the administration's medicare proposal in view of the broad support given the eldercare approach in the Congress.

My preference for the eldercare approach over the medicare plan is based on the fact that the eldercare proposal avoids compulsion, minimizes Federal regimentation, and allows a comprehensive range of benefits under State administered programs. Under eldercare the extent of aid to the recipient is based on his need for Government assistance in meeting his health-care requirements without requiring a "social-worker type" needs test.

The eldercare proposal would work as follows: Voluntary private health insurance plans would be used as the insuring intermediaries. State governments, assisted by Federal funds, would offer health insurance coverage to fit a variety of individual needs of the aged. The cost of such coverage would be borne completely by Government for those individuals with incomes falling below minimum limits set by each State. For those individuals with incomes exceeding the minimum but less than a maximum, the State would pay a part of the cost. For those individuals whose incomes exceed maximum limits, the State would pay nothing. Aged individuals would periodically make a simple statement of annual income to the State. On the basis of this income statement alone would eligibility be determined.

Principal reasons for opposing medicare

Medicare should not be enacted because:

(1) The so-called medicare program is a compulsory Federal plan that would impose additional regressive payroll taxes on the current working population regardless of *inability* to pay; partial health benefits are made available to the retired population regardless of individual *ability* to be self-supporting—rich and poor alike. (See tables 1 and 2 for OASDI tax rate schedules and table 3 for medicare tax rate schedule. Tables also show tax amount per individual. Tables 5 and 6 set forth data with

respect to combined OASDI and medicare tax rates and amounts. Tables follow at the end of these additional views.)

(2) Medicare would establish a massive Federal program financed by social security and administered by a central bureaucracy and would violate the established concept that the echelon of government closest to the people can be more efficient and responsive in administration of social programs.

(3) Medicare would initiate what would ultimately become a Federal monopoly in regard to the financing and rendering of health care with respect to our aged to the detriment of endeavors of the private sector; this result would impair the quality of health care, retard the advancement of medical science, and displace private insurance.

(4) Medicare would for the first time inject into our OASDI system *service* benefits as distinguished from predeterminable *cash* benefits with the consequence that unpredictable costs and overutilization would jeopardize the soundness and acceptability of the social security program as well as necessitate a vast and costly expansion of health care facilities.

(5) The consensus of nongovernmental actuaries experienced in health insurance matters holds that the medicare program is underfinanced; but even the inadequate financing provisions of the bill would mean that for many taxpayers more would be paid in social security taxes than would be paid in income taxes.

(6) The economic thrust of the higher employment taxes necessitated by the medicare programs would have immediate adverse impact on job opportunities and the problem would be further aggravated by the certain expansion of the program once started. (See table 4 for estimated aggregate payroll taxes.)

Principal reasons for introducing eldercare

The eldercare program, embodied in H.R. 3801, was introduced for committee consideration as a preferable alternative to medicare because:

(1) The eldercare proposal is a noncompulsory program permitting health care under State administered programs aimed at providing complete care for aged persons requiring help in meeting their health expenses without a "social-worker type" means test.

(2) The proposal would provide for State administration and the utilization of private insurance carriers, thereby assuring responsible and responsive administration.

(3) Eldercare would minimize the intrusion of inflexible governmental management on medical facilities and professional services.

(4) The eldercare proposal would neither interfere with nor endanger the established concept of confining OASDI benefits to cash payments and would avoid the risky adventure of service benefits—an adventure that is failing in virtually every other major country.

(5) The eldercare proposal would not require the imposition of higher regressive payroll taxes and it would not jeopardize the actuarial status of the present OASDI system.

GENERAL DISCUSSION

The biennial political issue of compulsory Federal health care under social security has been pending before the Congress for 20 years. In that interim there has been no meaningful fundamental improvement contained in the various modifications that have been advocated in the compulsory social security approach. The only variations in the different proposals advanced from time to time are: (1) Curtailments in the suggested benefits to make the alleged cost politically salable, (2) arbitrary adjustments in eligibility requirements and, more recently, (3) a new catchword title—"Medicare."

In this 20-year period during which the Congress has rejected compulsory Federal health programs, the Congress has acted to establish sound Federal-State voluntary programs capable of meeting the health needs of citizens unable to defray the financial burdens of their own health requirements. The most recent instance of responsible action in this regard occurred with the enactment of the Kerr-Mills program.

There has also occurred in this 20-year period a phenomenal growth in the proportion of our aged population covered by private health insurance protection so that today substantially more than 60 percent of persons 65 years and over have coverage. In the past 10 years the number of aged covered by private insurance has more than tripled and the percentage of those so protected is expected to surpass 75 percent by 1969. Now the Congress is being called upon to provide a compulsory political solution to a medical problem by enacting a plan that would impair State administered programs and would destroy the incentive for the financially able aged to provide for themselves through insurance.

The membership of the House of Representatives, in acting on the medicare political palliative should be cognizant of the meaningful fact that the two groups most knowledgeable of the medical and actuarial implications of the medicare proposal oppose its enactment—these groups are the physicians and the health insurance industry. The concerns expressed by these groups are sustained by events throughout the world where government health programs have reached the critical juncture of unforeseen increases in cost and declining quality of medical service. It is not by accident that the U.S. citizens have available to them the highest standard of health care in the world under our free enterprise system. The enactment of medicare will inescapably impair the quality and increase the cost of health care in this country similar to the deteriorating standards and increasing costs being experienced in such countries as Great Britain, France, and Italy.

The proponents of compulsory health care under social security have provided a separate "health" trust fund to alleviate concern over the impact the provision of medical service benefits may have on the system's ability to meet cash benefit obligations. This same "precautionary safeguard" was attempted in the establishment of the separate Federal disability insurance trust fund under social security in 1956, which will only be saved from insolvency in 1966 by a provision in the committee's bill which allocates a larger percentage of the payroll tax which supports all facets of the OASDI program.

The potential for the impairment of the solvency of the new "health" trust fund arises in part from the fact that present aged beneficiaries

would be eligible for benefits under the program without any contribution to the trust fund for health insurance benefits. Concern over this problem was expressed in September 1964 by the able chairman of the Committee on Ways and Means when he said of medicare:

> * * * a further very serious problem is the effect which the assumption of the liability for the hospital costs for all the currently retired persons will have on the social security program as a whole. I do not believe that it is generally understood that this unfunded liability would amount to at least $33 billion. It must be realized that the currently retired individuals under the social security program have not paid any taxes as such for hospital insurance benefits. This is where the prepayment argument * * * completely breaks down.

The esteemed chiarman of the Committee on Ways and Means has worked diligently and conscientiously to provide an adequate and sound social security program; and it is because of that fact that I believe his admonition should be brought to the attention of the House membership.

Thus, this unfunded liability makes it patent that to claim medicare is based on an insurance principle is to clutch at an illusion. The unfunded obligations of the present OASDI program, which currently exceed $300 billion under present law, will have many more billions of unfunded benefit commitments added by the institution of the new "medicare" program with its schedule of deferred tax increases which does not reach its ultimate effect until January 1, 1987. The first population group that will bear the full brunt of the tax burden is the group of citizens to be born 6 years from now; and that group will be called upon to pay for its benefits as well as share in defraying the benefit costs of the presently retired and of those now in the working force.

It is also to be noted that the present law limitation on earned income by beneficiaries for eligibility for cash benefits, the so-called retirement test, would not be applicable with respect to the health service benefits. The service benefits provided in this bill will create additional inequities in the OASDI program in that persons aged 65 who become sick will be eligible for benefits without paying and taxes for these added benefits, whereas a person aged 60 who is in need and has paid increased taxes will be denied benefits.

CONCLUSION

Although there are many provisions in H.R. 6675 which I believe to be meritorious, such as were referred to in the foregoing Separate Views, the compulsory health care features of the bill threaten danger to the entire social security structure. The melancholy prospect for medicare is that it will retard, not advance, the Nation's health and welfare. In opposing this medicare program for the compelling reasons presented, I pledge myself to continued endeavors to have favorable action taken on a sounder and more equitable approach to meeting the medical needs of our aged citizens. I respectfully urge my colleagues in the House to join the Republican members of the Committee on Ways and Means in this effort.

JOEL T. BROYHILL, *Member of Congress.*

TABLE 1.—*Tax rate, tax base, and tax amount applicable to employers and employees (each) under present law and under H.R. 6675* [1]

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM, 1965-87 AND AFTER

Year	Tax rate, employer and employee (each)		Tax base		Tax per employee with base wage under bill [2]			
					Amount of tax		Increase under bill	
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Over present law	Over 1965
	Percent	*Percent*						
1965	3.625	3.625	$4,800	$4,800	$174	$174.00		
1966	4.125	4.000	4,800	5,600	198	224.00	$26.00	$50.00
1967	4.125	4.000	4,800	5,600	198	224.00	26.00	50.00
1968	4.625	4.000	4,800	5,600	222	224.00	2.00	50.00
1969-70	4.625	4.400	4,800	5,600	222	246.40	24.40	72.40
1971-72	4.625	4.400	4,800	6,600	222	290.40	68.40	116.40
1973-75	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80
1976-79	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80
1980-86	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80
1987 and after	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80

[1] As described in Ways and Means Committee press release issued on Mar. 24, 1965, which summarizes the bill.
[2] Employers pay same amount on behalf of such employees.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 2.—*Tax rate, tax base, and tax amount applicable to self-employed persons under present law and under H.R. 6675* [1]

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM, 1965-87 AND AFTER

Year	Tax rate		Tax base		Tax per self-employed with base earnings under bill			
					Amount of tax		Increase under bill	
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Over present law	Over 1965
	Percent	*Percent*						
1965	5.4	5.4	$4,800	$4,800	$259.20	$259.20		
1966	6.2	6.0	4,800	5,600	297.60	336.00	$38.40	$76.80
1967	6.2	6.0	4,800	5,600	297.60	336.00	38.40	76.80
1968	6.9	6.0	4,800	5,600	331.20	336.00	4.80	76.80
1969-70	6.9	6.6	4,800	5,600	331.20	369.60	38.40	110.40
1971-72	6.9	6.6	4,800	6,600	331.20	435.60	104.40	176.40
1973-75	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1976-79	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1980-86	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1987 and after	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80

[1] As described in Ways and Means Committee press release, issued on Mar. 24, 1965, which summarizes the bill.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 3.—*Tax rate, tax base and tax amount, applicable to employers, employees, and self-employed persons under the basic health insurance program of H.R. 6675* [1]

1965-87 AND AFTER

Year	Tax on employer, employee, and self-employed (each)		
	Tax rate (percent)	Tax base	Tax amount [2]
1965			
1966	0.35	$5,600	$19.60
1967	.50	5,600	28.00
1968	.50	5,600	28.00
1969–70	.50	5,600	28.00
1971–72	.50	6,600	33.00
1973–75	.55	6,600	36.30
1976–79	.60	6,600	39.60
1980–86	.70	6,600	46.20
1987 and after	.80	6,600	52.80

[1] As described in Ways and Means Committee press release issued on Mar. 24, 1965, which summarizes the bill.

[2] For each self-employed person and employee with earnings or wage equal to or in excess of the tax base; employers pay same amount on behalf of such employees.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 4.—*Estimated aggregate taxes on employers, employees, and self-employed persons under present law and under H.R. 6675* [1]

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM, 1965-72 AND BASIC HEALTH INSURANCE PROGRAM, 1965-75, 1980, 1985, AND 1990

[In billions of dollars]

Year	Present law			H.R. 6675			
	Old-age and survivors insurance program	Disability insurance program	Total	Old-age and survivors insurance program	Disability insurance program	Basic health insurance program	Total
1965	$16.0	$1.2	$17.2	$16.0	$1.2		$17.2
1966	18.5	1.2	19.7	18.5	1.8	$1.6	21.9
1967	19.4	1.3	20.7	19.7	2.0	2.6	24.3
1968	22.2	1.3	23.5	20.3	2.1	2.8	25.2
1969	23.3	1.3	24.6	22.9	2.2	2.9	28.0
1970	24.0	1.4	25.4	24.0	2.2	3.0	29.2
1971	24.7	1.4	26.1	25.9	2.4	3.3	31.6
1972	25.4	1.4	26.8	27.2	2.5	3.5	33.2
1973	(2)	(2)	(2)	(2)	(2)	3.9	(2)
1974	(2)	(2)	(2)	(2)	(2)	4.1	(2)
1975	(2)	(2)	(2)	(2)	(2)	4.3	(2)
1980	(2)	(2)	(2)	(2)	(2)	6.1	(2)
1985	(2)	(2)	(2)	(2)	(2)	7.0	(2)
1990	(2)	(2)	(2)	(2)	(2)	9.0	(2)

[1] As described in Ways and Means Committee press release, issued on Mar. 24, 1965, which summarizes the bill.

[2] Not available.

Source: Compiled by staff of the Joint Committee on Internal Revenue Taxation from data supplied by Social Security Administration.

TABLE 5.—*Combined tax rate on employer and employee under present law and under H.R. 6675* [1]

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM AND BASIC HEALTH INSURANCE PROGRAM, 1965-87 AND AFTER

[In percent]

Year	Combined tax rate on employer and employee							
	Old-age, survivors, and disability insurance program		Basic health insurance program		Old-age, survivors, and disability insurance program and basic health insurance program			
							Change under bill	
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Over present law	Over 1965
1965	7.25	7.25			7.25	7.25		
1966	8.25	8.00		0.70	8.25	8.70	+0.45	+1.45
1967	8.25	8.00		1.00	8.25	9.00	+.75	+1.75
1968	9.25	8.00		1.00	9.25	9.00	−.25	+1.75
1969-70	9.25	8.80		1.00	9.25	9.80	+.55	+2.55
1971-72	9.25	8.80		1.00	9.25	9.80	+.55	+2.55
1973-75	9.25	9.60		1.10	9.25	10.70	+1.45	+3.45
1976-79	9.25	9.60		1.20	9.25	10.80	+1.55	+3.55
1980-86	9.25	9.60		1.40	9.25	11.00	+1.75	+3.75
1987 and after	9.25	9.60		1.60	9.25	11.20	+1.95	+3.95

[1] As introduced in the House of Representatives on Mar. 24, 1965.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 6.—*Combined tax on employer and employee under present law and under H.R. 6675* [1] [2]

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM AND BASIC HEALTH INSURANCE PROGRAM, 1965-87 AND AFTER

Year	Combined tax on employer and employee							
	Old-age, survivors, and disability insurance program		Basic health insurance program		Old-age, survivors, and disability insurance program and basic health insurance program			
							Increase under bill	
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Over present law	Over 1965
1965	$348	$348.00			$348	$348.00		
1966	396	448.00		$39.20	396	487.20	$91.20	$139.20
1967	396	448.00		56.00	396	504.00	108.00	156.00
1968	444	448.00		56.00	444	504.00	60.00	156.00
1969-70	444	492.80		56.00	444	548.80	104.80	200.80
1971-72	444	580.80		66.00	444	646.80	202.80	298.80
1973-75	444	633.60		72.60	444	706.20	262.20	358.20
1976-79	444	633.60		79.20	444	712.80	268.80	364.80
1980-86	444	633.60		92.40	444	726.00	282.00	378.00
1987 and after	444	633.60		105.60	444	739.20	295.20	391.20

[1] For employee with wage equal to or in excess of the tax base under the bill.
[2] As introduced in the House of Representatives on Mar. 24, 1965.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

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